State: District of Columbia Filing Company: UnitedHealthcare Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other

Product Name: DC-SG-UHIC-2019-01

Project Name/Number: /

# Filing at a Glance

Company: UnitedHealthcare Insurance Company

Product Name: DC-SG-UHIC-2019-01
State: District of Columbia

TOI: H16G Group Health - Major Medical Sub-TOI: H16G.003G Small Group Only - Other

Filing Type: Rate

Date Submitted: 06/01/2018

SERFF Tr Num: UHLC-131461282 SERFF Status: Submitted to State

State Tr Num: State Status: Co Tr Num:

Implementation 01/01/2019

Date Requested:

Author(s): Bonnie Barboza, Esther Drew, Michelle Lorenzo, Ryan Morgan, Alysia Krzanowski, Juliana

Mello

Reviewer(s):
Disposition Date:
Disposition Status:
Implementation Date:

State Filing Description:

State: District of Columbia Filing Company: UnitedHealthcare Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other

Product Name: DC-SG-UHIC-2019-01

Project Name/Number: /

#### **General Information**

Project Name: Status of Filing in Domicile:
Project Number: Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments:

Explanation for Combination/Other: Market Type: Group

Submission Type: New Submission Group Market Size: Small Group Market Type: Overall Rate Impact:

Filing Status Changed: 06/01/2018

State Status Changed: Deemer Date:

Created By: Ryan Morgan Submitted By: Ryan Morgan

Corresponding Filing Tracking Number:

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

Include Exchange Intentions: No

#### Filing Description:

We are proposing to set our 1st quarter 2019 rates on average 16.1% higher than our current 1st quarter 2018 rates. In addition, we are filing for quarterly rate increases as follows: 2Q19 +2.6%, 3Q19 +2.6%, 4Q19 +2.7%. These quarterly rate due to the combination of an annual trend of 8.1% as well as the phasing back in of ACA fees, which are expected to return in 2020.

The proposed rates and rate factors are in Exhibit 1. Benefit plan descriptions are in Exhibit 2, which also displays the metal level and actuarial value of each benefit plan.

# **Company and Contact**

#### **Filing Contact Information**

Juliana Mello, Associate Actuarial Analyst juliana\_mello1@uhc.com 185 Asylum St 860-702-5233 [Phone]

City Place 1

Hartford, CT 06103

#### **Filing Company Information**

UnitedHealthcare Insurance CoCode: 79413 State of Domicile: Connecticut Company Group Code: 707 Company Type: Life and

185 Asylum Street Group Name: Health

Hartford, CT 06103 FEIN Number: 36-2739571 State ID Number: 79413

(860) 702-5000 ext. [Phone]

# **Filing Fees**

Fee Required? No Retaliatory? No

Fee Explanation:

State: District of Columbia Filing Company: UnitedHealthcare Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other

Product Name: DC-SG-UHIC-2019-01

Project Name/Number: /

#### **Rate Information**

Rate data applies to filing.

Filing Method: Review & Approval

Rate Change Type: Increase

Overall Percentage of Last Rate Revision: 5.600%

Effective Date of Last Rate Revision: 01/01/2018

Filing Method of Last Filing: Review & Approval SERFF Tracking Number of Last Filing: UHLC-131016283

## **Company Rate Information**

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	Number of Policy Holders Affected for this Program:	Premium for	Maximum % Change (where req'd):	Minimum % Change (where req'd):
UnitedHealthcare Insurance Company	Increase	17.900%	17.900%	\$9,575,618	1,218	\$46,991,614	30.700%	11.000%

State: District of Columbia Filing Company: UnitedHealthcare Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other

Product Name: DC-SG-UHIC-2019-01

Project Name/Number: /

#### **Rate Review Detail**

**COMPANY:** 

Company Name: UnitedHealthcare Insurance Company

HHS Issuer Id: 25978

#### **PRODUCTS:**

Product Name	HIOS Product ID	HIOS Submission ID	Number of Covered
			Lives
EPO & POS			8509

Trend Factors: The current annual trend factor is 7.1% The proposed 2018 annual trend factor is 8.1%

FORMS:

New Policy Forms: POL.SHOP.I.2018.SG.DC, COC.SHOP.I.2018.SG.DC, SBN.CHP.I.2018.SG.DC.PL1,

SBN.CHP.I.2018.SG.DC.PL3, SBN.CHP.I.2018.SG.DC.PL4, SBN.CHP.I.2018.SG.DC.PL6, SBN.CHP.I.2018.SG.DC.PL14, SBN.CHP.I.2018.SG.DC.GO7, SBN.CHP.I.2018.SG.DC.GO8, SBN.CHP.I.2018.SG.DC.GO10, SBN.CHP.I.2018.SG.DC.GO11, SBN.CHP.I.2018.SG.DC.GO13, SBN.CHP.I.2018.SG.DC.GO21, SBN.CHP.I.2018.SG.DC.GO22, SBN.CHP.I.2018.SG.DC.SL8, SBN.CHP.I.2018.SG.DC.SL11, SBN.CHP.I.2018.SG.DC.SL15, SBN.CHP.I.2018.SG.DC.SL11, SBN.CHP.I.2018.SG.DC.SL17, SBN.CHP.I.2018.SG.DC.SL17, SBN.CHC.I.2018.SG.DC.PL1, SBN.CHC.I.2018.SG.DC.PL4, SBN.CHC.I.2018.SG.DC.GO11, SBN.CHC.I.2018.SG.DC.GO11, SBN.CHC.I.2018.SG.DC.GO14, SBN.CHC.I.2018.SG.DC.GO14, SBN.CHC.I.2018.SG.DC.GO22, SBN.CHC.I.2018.SG.DC.SL17, SBN.CHC.I.2018.SG.DC.GO21, SBN.CHC.I.2018.SG.DC.GO22, SBN.CHC.I.2018.SG.DC.SL15, SBN.CHC.I.2018.SG.DC.SL11, SBN.CHC.I.2018.SG.DC.SL11, SBN.CHC.I.2018.SG.DC.SL11, SBN.CHC.I.2018.SG.DC.SL15,

SBN.CHC.I.2018.SG.DC.BR4, RID.PDS.NET.I.2018.SG.DC, RID.PDS.NET-

OON.I.2018.SG.DC RID.PVCS.NET.I.2018.SG.DC, RID.PVCS.NET-

SBN.CHC.I.2018.SG.DC.SL16, SBN.CHC.I.2018.SG.DC.SL17,

OON.I.2018.SG.DC, RID.RX.NET.I.2018.SG.DC,

Affected Forms:

Other Affected Forms:

#### REQUESTED RATE CHANGE INFORMATION:

Change Period: Quarterly
Member Months: 106,051
Benefit Change: Increase

Percent Change Requested: Min: 11.4 Max: 27.7 Avg: 17.9

PRIOR RATE:

Total Earned Premium: 46,991,614.00 Total Incurred Claims: 38,303,687.00

Annual \$: Min: 157.21 Max: 1,089.75 Avg: 443.10

State: District of Columbia Filing Company: UnitedHealthcare Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other

Product Name: DC-SG-UHIC-2019-01

Project Name/Number: /

#### **REQUESTED RATE:**

Projected Earned Premium: 55,403,113.00 Projected Incurred Claims: 43,879,265.00

Annual \$: Min: 181.97 Max: 1,261.36 Avg: 518.43

State: District of Columbia Filing Company: UnitedHealthcare Insurance Company

**TOI/Sub-TOI:** H16G Group Health - Major Medical/H16G.003G Small Group Only - Other

Product Name: DC-SG-UHIC-2019-01

Project Name/Number: /

# Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		Rate Filing Exhibits		Revised	Previous State Filing Number: UHLC-131016283 Percent Rate Change Request: 17.9	DC-SG-UHIC-Exhibits 2019-1-v5.pdf,

Rate Factors Exhibit 1

(1) Base Rate: \$700.68

#### (2) Benefit Plan Ratios

	CH/I	NS (EPO) PI	ans		
	Medical	Rx			
	Plan	Plan	Metal	Actuarial	Plan
Product	Name	Name	Level	Value	Ratio
EPO	BH-F2	814	Platinum 1	88.8%	0.7628
EPO	BH-F5	820	Platinum 4	87.8%	0.8021
EPO	BH-FN	816	Gold 8	81.5%	0.5835
EPO	BH-FR	816	Gold 13	81.2%	0.6121
EPO	BH-E7	813	Gold 22	79.7%	0.6814
EPO	BH-FE	819	Gold 23	78.8%	0.5877
EPO	BH-FV	818	Gold 26	76.3%	0.5480
EPO	BH-FY	818	Silver 8	71.0%	0.4764
EPO	BH-FH	819	Silver 18	71.7%	0.4790
EPO-HSA	BH-EZ	816	Gold 1	80.4%	0.6346
EPO-HSA	BH-FZ	816	Silver 11	71.1%	0.5471
EPO-HSA	BH-E3	575	Bronze 4	61.3%	0.4090

		CH+/IN	IS (POS) Plans	6	
	Medical	Rx			
	Plan	Plan	Metal	Actuarial	Plan
Product	Name	Name	Level	Value	Ratio
POS	BH-FW	814	Platinum 1	88.8%	0.7745
POS	BH-F3	820	Platinum 4	87.8%	0.8142
POS	BH-E5	845	Platinum 14	91.4%	0.8397
POS	BH-FM	816	Gold 8	80.7%	0.5940
POS	BH-FX	816	Gold 10	81.2%	0.6040
POS	BH-FQ	816	Gold 13	81.2%	0.6224
POS	BH-E4	813	Gold 22	79.7%	0.6881
POS	BH-FF	819	Gold 23	78.8%	0.5977
POS	BH-FS	818	Gold 26	76.3%	0.5574
POS	BH-FT	818	Silver 8	81.5%	0.4852
POS	BH-FI	819	Silver 18	71.7%	0.4872
POS-HSA	BH-E6	816	Gold 1	80.4%	0.6471
POS-HSA	BH-EY	816	Gold 7	81.9%	0.7005
POS-HSA	BH-FU	816	Silver 11	71.1%	0.5582

#### (3) Effective Date Adjustment Factors (EDA's)

Effective Quarter	<u>Trend</u>	ACA Fees	<u>Total</u>
1st Quarter, 2019	1.0000	1.0000	1.000
2nd Quarter, 2019	1.0197	1.0066	1.026
3rd Quarter, 2019	1.0397	1.0132	1.053
4th Quarter, 2019	1.0602	1.0198	1.081

#### (4) Age Factors

<u>Age</u>	<u>Factor</u>	<u>Age</u>	<u>Factor</u>	<u>Age</u>	<u>Factor</u>
0-20	0.654	35	0.876	50	1.431
21	0.727	36	0.896	51	1.487
22	0.727	37	0.916	52	1.545
23	0.727	38	0.927	53	1.605
24	0.727	39	0.938	54	1.668
25	0.727	40	0.975	55	1.733
26	0.727	41	1.013	56	1.801
27	0.727	42	1.053	57	1.871
28	0.744	43	1.094	58	1.944
29	0.760	44	1.137	59	2.020
30	0.779	45	1.181	60	2.099
31	0.799	46	1.227	61	2.181
32	0.817	47	1.275	62	2.181
33	0.836	48	1.325	63	2.181
34	0.856	49	1.377	64 & older	2.181

#### DC Small Group - 2019 Portfolio - UnitedHealthcare Insurance Company

								- Ir	n-Netwo	'k		Out-of-Network					Co	payments				Medical				Rx					
	Plan Na	me		Metal	Act'l	Plan	Dedu	ıctible		OOP M	aximum	Dedu	ıctible		OOP N	laximum					OP	Surgery		Deduct.	Deduct.			1	Tier 2	Tier :	3
Product	Medical	Rx SC	CID	Level	Value	Ratio	Indiv.	Family	Coins	Indiv.	Family	Indiv.	Family	Coins	Indiv.	Family	PCP	SCP	UC	ER	Free-St.	Hospital	IP	Type	Type	Deduct.	Tier 1	Tier 2	spec. Tic	er 3 Spec	:. Tier 4
EPO	BH-F2	814 41842DC	0040059	Platinum 1	88.8%	0.7628	\$250	\$500	100%	\$2,500	\$5,000		•			•	\$15	\$30	\$15	\$250	\$0	\$250 POD		Emb	Sep		\$10	\$40 \$	100 \$	75 \$150	)
EPO	BH-F5	820 41842DC	0040060	Platinum 4	87.8%	0.8021	\$0	\$0	100%	\$5,000	\$10,000						\$15	\$30	\$15	\$250	\$0	\$150 POD	\$0	Emb	Sep		\$15	\$25 \$		50 \$150	
EPO	BH-FN	816 41842DC	0040091	Gold 8	80.7%	0.5835	\$1,250	\$2,500	80%	\$4,250	\$8,500						\$30	\$60	\$30		\$0 POD	\$250 POD		Emb	Sep		\$10	\$40 \$	\$120 \$7	75 \$150	)
EPO		816 41842DC		Gold 13	81.2%	0.6121	\$1,500	\$3,000		\$6,500	\$13,000						\$25	\$50	\$25	\$250 POD	\$0	\$250 POD		Emb	Sep					75 \$150	
EPO	BH-E7	813 41842DC	0040057	Gold 22	79.7%	0.6814	\$0	\$0		\$7,900	\$15,800						\$30	\$60	\$30	\$500	\$600	\$600	\$1000 x 3	Emb	Sep		\$10	\$50	\$0 \$1	100 \$0	\$150
EPO		819 41842DC		Gold 23	78.8%	0.5877	\$1,000	\$2,000		\$7,900	\$15,800						\$0	\$40	\$25					Emb	Sep	\$250				75 \$150	
EPO		818 41842DC		Gold 26	76.3%	0.5480	\$2,000	\$4,000		\$6,000	\$12,000						\$30	\$60 CAD	\$30	\$500 CAD	\$150 POD	\$300 POD	\$500/Admit	Emb	Sep	\$250				75 \$150	
EPO		818 41842DC		Silver 8	71.0%	0.4764	\$2,500	\$5,000		\$7,900	\$15,800						\$50	\$100	\$50		\$300	\$0 POD		Emb	Sep	\$250				75 \$150	
EPO		819 41842DC		Silver 18	71.7%	0.4790	\$4,250	\$8,500		\$7,900	\$15,800						\$0	\$50	\$25					Emb	Sep	\$250				75 \$150	
EPO-HSA		816 41842DC		Gold 1	80.4%	0.6346	\$1,400	\$2,800		\$3,500	\$7,000													NonEmb	Comb					75 \$150	
EPO-HSA		816 41842DC		Silver 11	71.1%	0.5471	\$2,600	\$5,200		\$6,700	\$13,400						\$25 CAD	\$50 CAD	\$25 CAD	\$150 CAD	\$0	\$250 POD	\$500/Admit	Ded NonEmb/OOPM Emb	Comb					75 \$150	j
EPO-HSA		575 41842DC		Bronze 4	61.3%	0.4090	\$6,700	\$13,400		\$6,700	\$13,400													Emb	Comb		\$0	+-		\$0 \$0	
POS		814 41842DC		Platinum 1	88.8%	0.7745	\$250	\$500		\$2,500	\$5,000	\$2,000	\$4,000	70%	\$6,000	\$12,000	\$15	\$30	\$15	\$250	\$0	\$250 POD		Emb	Sep					75 \$150	
POS		820 41842DC		Platinum 4	87.8%	0.8142	\$0	\$0		\$5,000	\$10,000	\$1,000	\$2,000	70%	\$6,000	\$12,000	\$15	\$30	\$15	\$250	\$0	\$150 POD	\$0	Emb	Sep					50 \$150	1
POS		845 41842DC			91.4%	0.8397	\$0	50		\$3,000	\$6,000	\$500	\$1,000	80%	\$3,000	\$6,000	\$10	\$20	\$10	\$200	\$150	\$150		Emb	Sep					75 \$0	_
POS		816 41842DC		Gold 8	80.7%	0.5940	\$1,250	\$2,500		\$4,250	\$8,500	\$3,000	\$6,000	70%	\$8,000	\$16,000	\$30	\$60	\$30		\$0 POD	\$250 POD		Emb	Sep					75 \$150	
POS		816 41842DC		Gold 10	81.2%	0.6040	\$750	\$1,500		\$6,500	\$13,000	\$2,000	\$4,000		\$15,000	\$30,000	\$20	\$40	\$20		\$0 POD	\$250 POD		Emb	Sep					75 \$150	
POS		816 41842DC		Gold 13	81.2%	0.6224	\$1,500	\$3,000			\$13,000	\$3,000			\$10,000		\$25	\$50	\$25	\$250 POD	\$0	\$250 POD		Emb	Sep					75 \$150	
POS		813 41842DC		Gold 22	79.7%	0.6881	\$0	\$0		\$7,900		\$15,000	\$30,000		\$30,000		\$30	\$60	\$30	\$500	\$600	\$600	\$1000 x 3	Emb	Sep						\$150
POS		819 41842DC		Gold 23	78.8%	0.5977	\$1,000	\$2,000		\$7,900	\$15,800	\$2,000	\$4,000		\$15,000		\$0	\$40	\$25					Emb	Sep	\$250				75 \$150	
POS		818 41842DC		Gold 26	76.3%	0.5574	\$2,000	\$4,000		\$6,000	, ,	\$5,000	\$10,000		\$15,000	, ,	\$30	\$60 CAD	\$30	\$500 CAD	\$150 POD	\$300 POD	\$500/Admit	Emb	Sep	\$250				75 \$150	
POS		818 41842DC		Silver 8	71.0%	0.4852	\$2,500	\$5,000		\$7,900	\$15,800	\$4,000	\$8,000		\$15,000		\$50	\$100	\$50		\$300	\$0 POD		Emb	Sep	\$250				75 \$150	
POS		819 41842DC		Silver 18	71.7%	0.4872	\$4,250	\$8,500		\$7,900	\$15,800	\$7,500	\$15,000		\$15,000	\$30,000	\$0	\$50	\$25					Emb	Sep	\$250				75 \$150	
POS-HSA				Gold 1	80.4%	0.6471	\$1,400	\$2,800		\$3,500	\$7,000	\$2,000	\$4,000	70%	\$6,000	\$12,000				£350 640				NonEmb	Comb					75 \$150	
POS-HSA		816 41842DC		Gold 7	81.9%	0.7005	\$1,500		100%			\$2,000			\$6,000	\$12,000	625 640	ć50.54B	635.640	\$250 CAD	ćo	6350 BOD	6500 (A d (A	Ded NonEmb/OOPM Emb	Comb					75 \$150	
PUS-HSA	RH-FU	816 41842DC	.0010043	Silver 11	71.1%	0.5582	\$2,600	\$5,200	100%	\$b,/00	\$13,400	\$4,000	\$8,000	80%	\$10,000	\$20,000	\$25 CAD	\$50 CAD	\$25 CAD	\$150 CAD	\$0	\$250 POD	\$500/Admit	Ded NonEmb/OOPM Emb	Comb		210	\$40 \$	5120 \$7	75 \$150	j

# Rate Changes - Base Rates, Benefit Plan Ratios and Effective Date Adjustment (EDA) Factors (from Exhibit 1)

															Year C	ver Yea	r Rate C	hange
					Curre	nt - 4th Qu	arter 201	.8 Rate		Proposed	- 1st Quarte	r 2019 Rate	% Rate		Min:	11.0%	Max:	30.7%
				Ва	se	Plan	EDA	4Q2018	1	Base	Plan	1Q2019	Change		1Q18	2Q18	3Q18	4Q18
	Plan I	Name		Ra	te	Ratio	Factor	Rate =		Rate	Ratio	Rate =	4Q18		to	to	to	to
Product	2018	2019	Rx	(a	)	(b)	(c)	(a x b x c)		(d)	(e)	(d x e)	to 1Q19		1Q19	2Q19	3Q19	4Q19
EPO	AT-ZX	BH-F2	814	\$605	.35	0.7005	1.053	\$446.52		\$700.68	0.7628	\$534.48	19.7%	2	26.0%	27.2%	28.3%	29.4%
EPO	AT-ZY	BH-F5	820	\$605	.35	0.7297	1.053	\$465.14		\$700.68	0.8021	\$562.02	20.8%	2	27.2%	28.4%	29.5%	30.7%
EPO	AT-ZP	BH-FN	816	\$605	.35	0.6061	1.053	\$386.35		\$700.68	0.5835	\$408.85	5.8%	2	11.4%	12.4%	13.4%	14.4%
EPO	AT-ZT	BH-FR	816	\$605	.35	0.6005	1.053	\$382.78		\$700.68	0.6121	\$428.89	12.0%	- :	18.0%	19.0%	20.1%	21.2%
EPO	AT-Y6	BH-E7	813	\$605	.35	0.6229	1.053	\$397.06		\$700.68	0.6814	\$477.44	20.2%	2	26.6%	27.8%	28.9%	30.0%
EPO	AT-ZM	BH-FY	818	\$605	.35	0.4966	1.053	\$316.55		\$700.68	0.4764	\$333.80	5.5%	2	11.0%	12.0%	13.0%	14.0%
EPO-HSA	AT-ZW	BH-FZ	816	\$605	.35	0.5307	1.053	\$338.29		\$700.68	0.5471	\$383.34	13.3%	2	19.3%	20.4%	21.5%	22.5%
EPO-HSA	AT-YX	BH-E3	575	\$605	.35	0.3971	1.053	\$253.12		\$700.68	0.4090	\$286.58	13.2%	2	19.2%	20.3%	21.4%	22.4%
POS	AT-ZO	BH-FW	814	\$605	.35	0.7121	1.053	\$453.92		\$700.68	0.7745	\$542.68	19.6%	2	25.9%	27.0%	28.1%	29.3%
POS	AT-ZR	BH-F3	820	\$605	.35	0.7419	1.053	\$472.91		\$700.68	0.8142	\$570.49	20.6%	2	27.0%	28.2%	29.3%	30.5%
POS	AT-ZA	BH-E5	845	\$605	.35	0.8254	1.053	\$526.14		\$700.68	0.8397	\$588.36	11.8%	2	17.8%	18.8%	19.9%	20.9%
POS	AT-ZQ	BH-FM	816	\$605	.35	0.6175	1.053	\$393.62		\$700.68	0.5940	\$416.20	5.7%	2	11.3%	12.3%	13.3%	14.3%
POS	AT-ZI	BH-FX	816	\$605	.35	0.6231	1.053	\$397.18		\$700.68	0.6040	\$423.21	6.6%	-	12.2%	13.2%	14.2%	15.2%
POS	AT-ZU	BH-FQ	816	\$605	.35	0.6113	1.053	\$389.66		\$700.68	0.6224	\$436.10	11.9%	-	17.8%	18.9%	20.0%	21.0%
POS	AT-Y7	BH-E4	813	\$605	.35	0.6294	1.053	\$401.20		\$700.68	0.6881	\$482.14	20.2%	2	26.5%	27.7%	28.8%	30.0%
POS	AT-ZZ	BH-FT	818	\$605	.35	0.5060	1.053	\$322.54		\$700.68	0.4852	\$339.97	5.4%	2	11.0%	12.0%	13.0%	14.0%
POS-HSA	AT-YS	BH-EY	816	\$605	.35	0.6876	1.053	\$438.30		\$700.68	0.7005	\$490.83	12.0%	2	17.9%	19.0%	20.0%	21.1%
POS-HSA	AT-ZV	BH-FU	816	\$605	.35	0.5413	1.053	\$345.04		\$700.68	0.5582	\$391.12	13.4%	:	19.4%	20.4%	21.5%	22.6%
EPO-HSA		BH-EZ	816	Nev	/ Ben	efit Plan				\$700.68	0.6346	\$444.65						
EPO		BH-FE	819	Nev	/ Ben	efit Plan				\$700.68	0.5877	\$411.79						
EPO		BH-FV	818	Nev	/ Ben	efit Plan				\$700.68	0.5480	\$383.97						
EPO		BH-FH	819	Nev	/ Ben	efit Plan				\$700.68	0.4790	\$335.63						
POS-HSA		BH-E6	816	Nev	<i>I</i> Ben	efit Plan				\$700.68	0.6471	\$453.41						
POS		BH-FF	819	Nev	/ Ben	efit Plan				\$700.68	0.5977	\$418.80						
POS		BH-FS	818	Nev	/ Ben	efit Plan				\$700.68	0.5574	\$390.56						
POS		BH-FI	819	Nev	<i>I</i> Ben	efit Plan				\$700.68	0.4872	\$341.37						

#### New 2019 Benefit Plans

		Metal	Plan
SCID	Product	Level	Name
41842DC0040061	EPO-HSA	Gold 1	BH-EZ
41842DC0040062	EPO	Gold 23	BH-FE
41842DC0040064	EPO	Gold 26	BH-FV
41842DC0040063	EPO	Silver 18	BH-FH
41842DC0010081	POS-HSA	Gold 1	BH-E6
41842DC0010082	POS	Gold 23	BH-FF
41842DC0010084	POS	Gold 26	BH-FS
41842DC0010083	POS	Silver 18	BH-FI

#### Terminated 2018 Benefit Plans

		Metal	Plan
SCID	Product	Level	Name
41842DC0040053	EPO	Gold 14	AT-YV
41842DC0040054	EPO	Gold 21	AT-YZ
41842DC0040052	EPO	Silver 12	AT-YU
41842DC0040055	EPO	Silver 15	AT-Y2
41842DC0040056	EPO	Silver 16	AT-Y4
41842DC0040058	EPO	Silver 17	AT-Y8
41842DC0040047	EPO-HSA	Gold 11	AT-ZK
41842DC0010001	POS	Platinum 3	AT-YT
41842DC0010031	POS	Platinum 6	AT-ZS
41842DC0010075	POS	Gold 21	AT-Y1
41842DC0010076	POS	Silver 15	AT-Y3
41842DC0010077	POS	Silver 16	AT-Y5
41842DC0010079	POS	Silver 17	AT-Y9
41842DC0010069	POS-HSA	Gold 11	AT-ZJ

#### 2018 Benefit Plans with Plan Changes (Uniform Modification)

		Metal	2018	2019		Value of Benefit
SCID	Product	Level	Name	Name	Benefit Plan Changes	Change on Rate
					INN OOPM from 2000/4000 to 2500/5000	
					Change Minor Lab from 100% to \$30	
41842DC0040059	EPO	Platinum 1	AT-ZX	BH-F2	MH OP changed from \$15 to \$30	-0.6%
41842DC0040060	EPO	Platinum 4	AT-ZY	BH-F5	MH OP changed from \$15 to \$30	0.0%
					INN Ded from 1000/2000 to 1250/2500	
					INN OOPM from 3750/7500 to 4250/8500	
41842DC0040091	EPO	Gold 8	AT-ZP	BH-FN	MH OP Changed from \$30 to \$60 INN Ded from 1000/2000 to 1500/3000	-2.7%
					INN OOPM from 5000/10000 to 6500/13000	
					Lab/Xray from \$50+D&C to D&C	
					ER from \$100+D&C to \$250+D&C	
41842DC0040045	EPO	Gold 13	AT-ZT	BH-FR	MH OP changed from \$25 to \$50	-4.1%
410420C0040043	LIO	G0IG 13	AI-ZI	DITTIN	INN OOPM from 7350/14700 to 7900/15800	4.170
41842DC0040057	EPO	Gold 22	AT-Y6	BH-E7	MH OP Changed from \$30 to \$60	-0.2%
410420C0040037	LIO	G010 22	AI-IU	DII-L/	INN Ded from 2000/4000 to 2500/5000	0.270
					INN OOPM from 7300/14600 to 7900/15800	
					MH OP Changed from \$50 to \$100	
41842DC0040101	EPO	Silver 8	AT-ZM	BH-FY	MH Part Hosp Subj to Ded changed from N to Y	-3.5%
41842DC0040046	EPO-HSA	Silver 11	AT-ZW	BH-FZ	INN OOPM from 6500/13000 to 6700/13400	-2.5%
41842DC0040008	EPO-HSA	Bronze 4	AT-YX	BH-E3	INN Ded & OOPM from 6650/13300 to 6700/13400	-0.3%
					INN OOPM from 2000/4000 to 2500/5000	
					Change Minor Lab from 100% to \$30	
41842DC0010066	POS	Platinum 1	AT-ZO	BH-FW	MH OP Changed from \$15 to \$30	-0.6%
41842DC0010068	POS	Platinum 4	AT-ZR	BH-F3	MH OP changed from \$15 to \$30	0.0%
41842DC0010074	POS	Platinum 14	AT-ZA	BH-E5	MH OP changed from \$10 to \$20	0.0%
					INN Dea from 1000/2000 to 1250/2500	
					INN OOPM from 3750/7500 to 4250/8500	
					OON Ded from 2000/4000 to 3000/6000	
					OON OOPM from 6000/12000 to 8000/16000	
41842DC0010054	POS	Gold 8	AT-ZQ	BH-FM	MH OP Changed from \$30 to \$60	-2.8%
					INN OOPM from 5000/10000 to 6500/13000	
41842DC0010032	POS	Gold 10	AT-ZI	BH-FX	MH OP changed from \$20 to \$40	-1.9%
					INN OOPM from 5000/10000 to 6500/13000	
					OON Ded from 2000/4000 to 3000/6000	
					Lab/Xray from \$50+D&C to D&C	
41942DC0010042	POS	Cold 12	AT 711	BH FO	ER from \$100+D&C to \$250+D&C	-4.1%
41842DC0010042	PUS	Gold 13	AT-ZU	BH-FQ	INN OOPM from 7350/14700 to 7900/15800	-4.1%
41842DC0010078	POS	Gold 22	AT-Y7	BH-E4	·	-0.2%
41842DC0010078	PU3	GOIU 22	AI-T/	ВП-Е4	MH OP Changed from \$30 to \$60	-0.270
					INN OOPM from 7300/14600 to 7900/15800	
					OON OOPM from 10000/20000 to 15000/20000	
					MH OP changed from \$50 to \$100	
41842DC0010080	POS	Silver 8	AT-ZZ	BH-FT	MH Part Hosp Subj to Ded changed from N to Y	-3.6%
41842DC0010080 41842DC0010006	POS-HSA	Gold 7	AT-YS	BH-EY	INN OOPM from 2800/5600 to 3000/6000	-1.8%
41842DC0010000 41842DC0010043	POS-HSA	Silver 11	AT-ZV	BH-FU	INN OOPM from 6500/13000 to 6700/13400	-0.5%
.157200010045	. 55 H5A	JIIVCI 11	711 24	51110	551 11 115111 5550/ 15555 to 5750/ 15400	0.570

#### Unchanged 2018 Benefit Plans - Continued into 2019

There are no unchanged benefit plans

# Rate Calculation Formula

Monthly premium =

Base Rate

x Plan ratio

x Effective date adjustment (EDA) factor for plan effective or renewal date

x Sum of member age factors for the group

# Rating Example

Benefit Plan: EPO plan BH-F2 with Rx 814

Effective Date: 1/1/19

Census:

		Member A	_	Age Factors					
	EE Age	Spouse Age	Child #1	Child #2		<u>EE</u>	Spouse	Child #1	Child #2
EE #1	43	41	10	15		1.094	1.013	0.654	0.654
EE #2	35	36	5	9		0.876	0.896	0.654	0.654
EE #3	53	55	19			1.605	1.733	0.654	

Total Members: 11 Sum of Age Factors: 10.487

#### Rate Calculation

		Rating Factor	Exhibit 1	1 Location
\$70	00.68	Base Rate		(1)
0.	7628	Benefit Plan Ratio (BH-F2	w 814)	(2)
1.	.000	EDA Factor (1Q19)		(3)
10	).487	Group Age Factor		(4)
\$5,6	605.08			

**Total Monthly Premium** 

							_					_
					2047	2040		t Model	New N		Poto Chongo	Revenue
Linaman	Dlan Nam	o Matal Laval	Draduat	Du Dlan	2017	2018		s & PMPM	Plan Ratio		Rate Change	Nuetral
<u>License</u> OCI		ne Metal Level	Product HMO	Rx Plan YM	Members	Base Rate	Medical	PMPM 277.75	Medical 0.6700	PMPM 204.15	by Plan	PMPM 382.91
OCI	FZ-K AL-EJ	Bronze 4 Gold 10	HMO HMO	YM	367 768	565.75 565.75	0.6677	377.75 350.93	0.6790 0.6106	384.15 345.42	1.4% -1.9%	344.31
OCI	AE-CL	Gold 10	HMO	YM	422	565.75	0.6203 0.6515	368.59	0.6372	360.48	-2.5%	359.32
OCI	AE-CL AE-CN	Gold 10 Gold 11	HMO	YM	454	565.75	0.5309	300.36	0.5450	308.35	2.3%	307.36
OCI	AL-EL	Gold 11	HMO	YM	149	565.75	0.6617	374.36	0.6734	380.99	1.4%	379.76
OCI	AM-4N	Gold 11	HMO	YM	218	565.75	0.6076	343.75	0.6000	339.43	-1.6%	338.34
OCI	63-Q	Gold 8	HMO	YM	334	565.75	0.6339	358.63	0.6213	351.51	-2.3%	350.38
OCI	AE-CM	Platinum 1	HMO	YM	3151	565.75	0.7688	434.95	0.7721	436.79	0.1%	435.39
OCI	AJ-EU	Platinum 2	HMO	ZR	1413	565.75	0.7735	437.61	0.7747	438.28	-0.2%	436.88
OCI	AJ-ET	Platinum 4	HMO	ZU	1536	565.75	0.8162	461.77	0.8195	463.63	0.1%	462.14
OCI	AL-EK	Silver 11	нмо	YM	176	565.75	0.5294	299.51	0.5466	309.24	2.9%	308.25
UHCMA	AL-DU	Bronze 4	CORE	YM	33	543.74	0.4120	224.02	0.4253	231.26	2.9%	230.52
UHCMA	AL-EI	Gold 10	CORE	YM	95	543.74	0.6395	347.72	0.6294	342.25	-1.9%	341.15
UHCMA	AL-D2	Gold 11	CORE	YM	53	543.74	0.6822	370.94	0.6942	377.49	1.4%	376.28
UHCMA	AD-7N	Gold 11	CORE	YM	31	543.74	0.5473	297.59	0.5619	305.52	2.3%	304.54
UHCMA	AL-DT	Silver 11	CORE	YM	35	543.74	0.5458	296.77	0.5635	306.41	2.9%	305.42
UHCMA	AD-70	Silver 11	CORE	YM	74	543.74	0.4256	231.42	0.4360	237.05	2.1%	236.29
UHCMA	AL-FH	Silver 7	CORE	D0	55	543.74	0.5108	277.74	0.5087	276.60	-0.7%	275.71
UHCMA	FW-6	Silver 7	CORE	YM	63	543.74	0.6884	374.31	0.7000	380.62	1.4%	379.40
UHCMA	AL-DN	Bronze 4	NAVIGATE	YM	139	543.74	0.3997	217.33	0.4126	224.32	2.9%	223.60
UHCMA	AD-7G	Bronze 4	NAVIGATE	YM	104	543.74	0.4128	224.46	0.4229	229.94	2.1%	229.20
UHCMA	AL-DS	Gold 10	NAVIGATE	YM	743	543.74	0.6203	337.28	0.6106	331.98	-1.9%	330.92
UHCMA	6U-4	Gold 11	NAVIGATE	YM	72	543.74	0.6677	363.06	0.6790	369.20	1.4%	368.02
UHCMA	AL-DO	Gold 11	NAVIGATE	YM	465	543.74	0.6617	359.79	0.6734	366.16	1.4%	364.99
UHCMA	AD-7F	Silver 11	NAVIGATE	YM	117	543.74	0.5309	288.67	0.5450	296.36	2.3%	295.40
UHCMA	AL-DM	Silver 11	NAVIGATE	YM	99	543.74	0.5294	287.86	0.5466	297.21	2.9%	296.26
UHCMA	AL-FG	Silver 7	NAVIGATE	D0	70	543.74	0.4954	269.37	0.4934	268.30	-0.7%	267.44
UHIC	AL-JD	Bronze 4	EPO	YM	133	605.35	0.3997	241.96	0.4126	249.74	2.9%	248.94
UHIC	AH-SY	Bronze 4	EPO	YM	77	605.35	0.4128	249.89	0.4229	255.99	2.1%	255.17
UHIC	AL-D1	Gold 11	EPO	YM	1649	605.35	0.6617	400.56	0.6734	407.65	1.4%	406.34
UHIC	FW-1	Gold 11	EPO	YM	852	605.35	0.6677	404.19	0.6790	411.03	1.4%	409.71
UHIC	AL-JF	Gold 13	EPO	YM	1622	605.35	0.6630	401.35	0.6549	396.46	-1.5%	395.19
UHIC	AD-7I	Gold 13	EPO	YM	884	605.35	0.6880	416.48	0.6928	419.39	0.4%	418.05
UHIC	AL-FF	Gold 14	EPO	ZT	234	605.35	0.5933	359.15	0.5879	355.90	-1.2%	354.76
UHIC	60-J	Gold 8	EPO	YM	1381	605.35	0.6076	367.81	0.6000	363.18	-1.6%	362.02
UHIC	AL-JI	Silver 11	EPO	YM	609	605.35	0.5294	320.47	0.5466	330.89	2.9%	329.83
UHIC	AD-7L	Silver 11	EPO	YM	673	605.35	0.5309	321.38	0.5450	329.93	2.3%	328.88
UHIC	AL-C8	Silver 3	EPO	YM	206	605.35	0.5243	317.39	0.5433	328.91	3.3%	327.85
UHIC	AD-7C	Silver 3	EPO	YM	460	605.35	0.5295	320.53	0.5427	328.53	2.2%	327.48
UHIC	AL-DV	Silver 7	EPO	D0	209	605.35	0.4954	299.89	0.4934	298.70	-0.7%	297.74
UHIC	AD-7P	Silver 7	EPO	D0	222	605.35	0.5535	335.06	0.5441	329.35	-2.0%	328.30
UHIC	AL-D3	Silver 8	EPO	ZT	216	605.35	0.5063	306.49	0.5038	304.99	-0.8%	304.02
UHIC	60-S	Silver 8	EPO	ZT	78	605.35	0.5491	332.40	0.5403	327.06	-1.9%	326.01
UHIC	AL-DC	Gold 1	POS	YM	1623	605.35	0.6528	395.17	0.6649	402.48	1.5%	401.19
UHIC	6Y-Y	Gold 1	POS	YM	1137	605.35	0.6599	399.47	0.6711	406.25	1.4%	404.94
UHIC	AL-DY	Gold 10	POS	YM	5218	605.35	0.6317	382.40	0.6219	376.49	-1.9%	375.28
UHIC	AD-7S	Gold 10	POS	YM	4798	605.35	0.6627	401.17	0.6485	392.56	-2.5%	391.30
UHIC	AL-DZ	Gold 11	POS	YM	1731	605.35	0.6738	407.88	0.6860	415.27	1.5%	413.93
UHIC	FW-W	Gold 11	POS	YM	487	605.35	0.6795	411.34	0.6913	418.46	1.4%	417.12
UHIC	AL-JG	Gold 13	POS	YM	3611	605.35	0.6747	408.43	0.6666	403.53	-1.5%	402.23
UHIC	AD-7J	Gold 13	POS	YM	2391	605.35	0.6996	423.50	0.7045	426.45	0.4%	425.08
UHIC	AL-C9	Gold 7	POS	YM	4545	605.35	0.6824	413.09	0.6976	422.28	1.9%	420.92
UHIC	AD-7D	Gold 7	POS	YM	5377	605.35	0.6924	419.14	0.7063	427.58	1.7%	426.21
UHIC	60-K	Gold 8	POS	YM	2136	605.35	0.6190	374.71	0.6114	370.09	-1.6%	368.90
UHIC	AL-DX	Gold 9	POS	YM	2092	605.35	0.6407	387.85	0.6323	382.79	-1.6%	381.56
UHIC	AD-7R	Gold 9	POS	YM	1751	605.35	0.6699	405.52	0.6567	397.55	-2.3%	396.28
UHIC	AD-7H	Platinum 1	POS	YM	9126	605.35	0.7803	472.35	0.7835	474.30	0.1%	472.78
UHIC	AD-69	Platinum 12	POS	263	1567	605.35	0.8383	507.46	0.8445	511.25	0.4%	509.61
UHIC	AD-7A	Platinum 13	POS	263	284	605.35	0.8166	494.33	0.8258	499.90	0.8%	498.29
UHIC	AL-DI	Platinum 13	POS	263	406	605.35	0.8166	494.33	0.8258	499.90	0.8%	498.29
UHIC	AD-7B	Platinum 14	POS	263	3624	605.35	0.8437	510.73	0.8493	514.10	0.3%	512.45
UHIC	AL-DJ	Platinum 14	POS	263	3688	605.35	0.8437	510.73	0.8493	514.10	0.3%	512.45
UHIC	AJ-EV	Platinum 2	POS	ZR	4705	605.35	0.7839	474.53	0.7852	475.30	-0.2%	473.77
UHIC	6Y-5	Platinum 3	POS	ZV	3676	605.35	0.7456	451.35	0.7487	453.25	0.1%	451.80
UHIC	AJ-EW	Platinum 4	POS	ZU	12764	605.35	0.8321	503.71	0.8339	504.79	-0.1%	503.17
UHIC	AJ-EX	Platinum 5	POS	ZV	6992	605.35	0.7935	480.35	0.7973	482.65	0.2%	481.10
UHIC	AJ-EY	Platinum 6	POS	ZU	3460	605.35	0.8209	496.93	0.8213	497.19	-0.3%	495.59
UHIC	AL-JH	Silver 11	POS	YM	666	605.35	0.5402	327.01	0.5580	337.78	3.0%	336.69
UHIC	AD-7K	Silver 11	POS	YM	622	605.35	0.5415	327.80	0.5560	336.60	2.4%	335.52
UHIC	AL-DA	Silver 3	POS	YM	309	605.35	0.5350	323.86	0.5546	335.72	3.3%	334.65
UHIC	AD-7E AL-DB	Silver 3	POS POS	YM	449 764	605.35 605.35	0.5400 0.5041	326.89	0.5536	335.11	2.2%	334.03
UHIC		Silver 5		YM				305.16	0.5165	312.68	2.1%	311.68
UHIC	AJ-SW	Silver 5	POS	YM	258	605.35	0.5043	305.28	0.5132	310.66	1.4%	309.66
UHIC	AL-DW	Silver 7	POS	D0	477 522	605.35 605.35	0.5048 0.5629	305.58	0.5030	304.48	-0.7%	303.50
UHIC	AD-7Q	Silver 7	POS	D0	533	003.33	0.3029	340.75	0.5536	335.13	-2.0%	334.05

Total 2017 membership in ACA plans: Average rate PMPM using the current pricing model: Average rate PMPM using the new pricing model: Revenue Neutrality Adjustment: 
 112,008
 112,008

 \$434.68
 Current Revenue:
 \$48,687,794

 \$436.08
 New Revenue:
 \$48,687,794

 -0.3%
 Change in Revenue:
 0.0%

## Member Months, Earned Premium & Incurred Claim Experience - UHIC

		Earned	Incurred	Risk	Claim		Galaxy
<u>Month</u>	<u>Members</u>	<u>Premium</u>	<u>Claims</u>	<u>Adjustment</u>	<u>PMPM</u>	Loss Ratio	Rx Rebate
Jan-15	7,112	3,259,621	1,842,340	-1.0%	258.88	57.1%	(91,887)
Feb-15	7,175	3,269,145	1,865,667	-1.0%	259.81	57.6%	(108,709)
Mar-15	7,270	3,277,765	2,580,877	-1.0%	354.79	79.5%	(114,105)
Apr-15	7,280	3,259,077	2,182,009			67.6%	(134,817)
May-15	7,314	3,246,183	2,041,479		279.08	63.5%	(126,305)
Jun-15	7,347	3,232,514	2,409,184	-1.0%	327.70	75.2%	(124,245)
Jul-15	7,454	3,265,490	2,471,857		331.37	76.4%	(124,558)
Aug-15	7,486	3,269,572	2,487,256	-1.0%	331.79	76.7%	(135,094)
Sep-15	7,594	3,286,894	2,316,384	-1.0%		71.1%	(142,077)
Oct-15	7,641	3,307,722	2,272,101	-1.0%		69.4%	(128,696)
Nov-15	7,699	3,317,859	2,498,466	-1.0%	324.29	76.0%	(127,257)
Dec-15	7,796	3,298,029	2,612,456	-1.0%	335.13	80.0%	(141,651)
Jan-16	7,809	3,353,774	2,153,981	-5.1%	275.83	67.7%	(140,886)
Feb-16	7,812	3,351,827	3,004,471	-5.1%	384.60	94.5%	(154,577)
Mar-16	7,785	3,353,929	2,249,265		288.92	70.7%	(172,682)
Apr-16	7,926	3,421,270	2,478,744	-5.1%		76.3%	(170,024)
May-16	8,015	3,459,521	2,519,209		314.31	76.7%	(142,711)
Jun-16	8,119	3,518,895	2,369,236		291.81	70.9%	(166,726)
Jul-16	8,182	3,564,006	2,281,331		278.82	67.5%	(148,666)
Aug-16	8,310	3,632,483	2,516,157	-5.1%	302.79	73.0%	(170,589)
Sep-16	8,284	3,671,810	2,484,192	-5.1%	299.88	71.3%	(165,862)
Oct-16	8,188	3,664,223	2,458,794		300.29	70.7%	(146,466)
Nov-16	8,140	3,565,311	2,623,538		322.30	77.5%	(165,211)
Dec-16	8,562	3,861,090	2,413,240		281.85	65.9%	(167,575)
Jan-17	8,504	3,813,448	2,708,879	0.5%	318.54	70.7%	(175,137)
Feb-17	8,681	3,879,846	3,048,120	0.5%	351.13	78.2%	(178,699)
Mar-17	8,751	3,890,580	3,123,695	0.5%	356.95	79.9%	(194,151)
Apr-17	8,707	3,846,903	2,631,962	0.5%	302.28	68.1%	(174,483)
May-17	8,805	3,876,483	3,362,590	0.5%	381.90	86.4%	(204,056)
Jun-17	8,826	3,868,931	3,973,774	0.5%	450.23	102.2%	(193,693)
Jul-17	8,799	3,867,279	3,977,312	0.5%	452.02	102.4%	(192,695)
Aug-17	8,853	3,885,803	3,333,221	0.5%	376.51	85.4%	(181,309)
Sep-17	8,779	3,853,145	2,912,526	0.5%	331.76	75.2%	(179,533)
Oct-17	8,882	3,928,452	3,145,515	0.5%	354.14	79.7%	(123,484)
Nov-17	9,062	3,970,810	3,478,254	0.5%	383.83	87.2%	(93,955)
Dec-17	9,402	4,153,830	3,517,261	0.5%	374.10	84.3%	(2,606)
2017 Total	106,051	46,835,510	39,213,109	0.5%	369.76	83.3%	(1,893,802)

**Certification for AV Calculator** Exhibit B

#### Estimation of fit of plan design into the parameters of AV calculator

Metallic Plan (e)	INN Coins	OP Copay Free Standing	OP Copay Hospital	Imaging (CT/PET Scans, MRIs) Free Standing	Imaging (CT/PET Scans, MRIs) Hospital	Imaging (CT/PET Scans, MRIs)	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Specialty Drugs (i.e. high-cost)	Methodology
Bronze 4	100%	D&C	D&C	D&C	D&C			\$0.00	d
Silver 8	70%	\$300	D&C	\$300	D&C	53.6%/D&C	29.2%/D&C	\$120.00	b,c,d
Silver 11	100%	D&C	\$250+D&C	D&C	\$250+D&C	D&C/61.3%	D&C/41.0%	\$120.00	a, b, c, d
Silver 18	70%	D&C	D&C	D&C	D&C			\$120.00	c,d
Silver 19	70%	D&C	D&C	D&C	D&C			\$120.00	c,d
Gold 1	90%	D&C	D&C	D&C	D&C			\$120.00	c,d
Gold 7	100%	D&C	D&C	D&C	D&C			\$120.00	c,d
Gold 8	80%	D&C	\$250+D&C	D&C	\$250+D&C	D&C/48.6%	D&C/31.3%	\$120.00	a,b,c,d
Gold 10	80%	D&C	\$250+D&C	D&C	\$250+D&C	D&C/48.6%	D&C/31.3%	\$120.00	a,b,c,d
Gold 11	100%	D&C	\$150+D&C	D&C	\$150+D&C	D&C/76.5%	D&C/63.5%	\$120.00	a,b,c,d
Gold 13	100%	D&C	\$250+D&C	D&C	\$250+D&C	D&C/60.78%	D&C/39.09%	\$120.00	a,b,c,d
Gold 22	100%	\$600	\$600	\$300	\$300	•	•	\$50.00	c,d
Gold 22 - OCI	100%	\$700	\$700	\$350	\$350			\$50.00	c,d
Gold 23	80%	D&C	D&C	\$500	\$500			\$120.00	c,d
Gold 25	80%	D&C	D&C	\$500	\$500			\$120.00	c,d
Gold 26	100%	\$150+D&C	\$300+D&C	\$150+D&C	\$300+D&C	76.5%/52.9%	63.5%/26.91%	\$120.00	a,b,c,d
Platinum 1	100%	D&C	\$250+D&C	D&C	\$250+D&C	D&C/58.4%	D&C/36.9%	\$100.00	a,b,c,d
Platinum 4	100%	D&C	\$150+D&C	D&C	\$150+D&C	FS vs. H Run	FS vs. H Run	\$100.00	a,b,c,d
Platinum 4 - OCI	100%	\$75+D&C	\$120+D&C	\$/5+D&C	\$120+D&C	FS vs. H Run	FS vs. H Run	\$100.00	a,p,c,u
Platinum 14	100%	\$150	\$150	\$150	\$150			\$40.00	c,d

#### Methodology

- a) An effective coinsurance for Per-Occurrence Deductibles on Imaging services and Outpatient facility fee was calculated based on unit costs derived from UnitedHealthcare's proprietary pricing model.
- Ointeurneathicate's prophetally printing involves.

  In Value is the blend of Free-Standing and Hospital setting run, where weight of Free Standing and Hospital Setting are adjusted based on actual utilization of free standing and hospital facilities by service categories.

  C) Speciality Rx: Entered the Rx Tier cost share with the highest specialty drug utilization per UnitedHealthcare's proprietary pircing mouet.

  d) See Exhibit 2 for plan benefit description, and for tie-in to benefit plan name.

#### Certification

For plan design features that do not fit into the parameters of the AV Calculator, I certify that both the methodology and the calculated estimated values are in accordance with generally accepted actuarial principles and methodologies.

Ryan Morgan
Ryan Morgan, FSA, MAAA

#### **Explanation of PPACA Fees and Development of Fee Effective Date Factors by Quarter**

The Patient Protection and Affordable Care Act (PPACA) includes several taxes and fees which will increase health insurance costs and need to be reflected in premium.

<u>Insurer Fee.</u> This is a permanent fee that applies to fully insured coverage, estimated to have an impact of 2.65%. However, *H.R. 195: Extension of Continuing Appropriations Act, 2018* "suspends for 2019 the annual fee imposed on certain health insurance providers based on market share." So for policy year periods that begin in February 2019, one of the 12 months is in calendar year 2020, requiring an insurer fee of 1/12 x 2.65% = 0.22%. Similarly, later policy period start dates in 2019 require a higher fee, as more of the premium is in calendar year 2020. The chart below details the needed fee by policy period effective month.

<u>Risk Adjustment Fee.</u> The fee pmpm for 2019 of \$0.15 pmpm is from the proposed 2019 CMS Notice of Benefit and Payment Parameters. The \$0.15 pmpm represents an estimated 0.03% of premium.

PCORI Fee. Policy periods effective after 10/1/2018 do not have to pay this fee. Therefore, this fee is \$0.00 in 2019.

Policy	# Months					Average	Fee		Fee
Period	in					Fee	Included	Additional	Effective
Effective	2020	Risk Adj.	Inquiror		2019	Per	in 1Q19	Fee	Date
		•	Insurer						
Date	Year	Fee	Fee	Total	Quarter	Quarter	Base Rate	Required	Factor
1/1/19	0	0.03%	0.00%	0.03%					
2/1/19	1	0.03%	0.22%	0.25%	1Q19	0.25%	0.25%	0.00%	1.0000
3/1/19	2	0.03%	0.44%	0.47%					
4/1/19	3	0.03%	0.66%	0.69%					
5/1/19	4	0.03%	0.88%	0.91%	2Q19	0.91%	0.25%	0.66%	1.0066
6/1/19	5	0.03%	1.10%	1.13%					
7/1/19	6	0.03%	1.32%	1.35%					
8/1/19	7	0.03%	1.54%	1.57%	3Q19	1.57%	0.25%	1.32%	1.0132
9/1/19	8	0.03%	1.76%	1.79%					
10/1/19	9	0.03%	1.99%	2.02%					
11/1/19	10	0.03%	2.21%	2.24%	4Q19	2.24%	0.25%	1.99%	1.0199
12/1/19	11	0.03%	2.43%	2.46%					
1/1/20	12	0.03%	2.65%	2.68%					<u> </u>

# DC Small Group Rate Review - Development of Underwriting Loss Ratio

## Total for UHIC, UHCMA, and OCI

	Total
Experience 1/1/2018-12/31/2018	
1a. Member Months	118,371
1b. Incurred Claims	\$41,935,370
1c. Claim PMPM (1b/1a)	\$354.27
1d. Earned Premium	\$51,867,362
1e. Premium PMPM (1d/1a)	\$438.18
1f. Loss Ratio (1c/1e)	80.9%
2a. Claim trend	1.177
From center of experience period: 7/1/17	
to average center of 1Q19 pricing period: 7/1/19, 8/1/19, 9/1	./19
(25 months at 8.1% annual rate)	
2b. Claim cost subtotal (1e x 2a)	\$416.82
2c. Admin, Profit & Taxes	\$109.71
2d. Needed revenue PMPM (2b + 2c)	\$526.53
2e. Risk Adjustment (0.7% Payer)	\$3.60
2f. Needed Revenue PMPM 1/1/18 eff (2d + 2e)	\$530.13
3a. Proposed DCSG Total 1Q19 Medical Base Rate*	\$697.52
3b. Average Plan Rel	0.7259
3c. Average Age Factor	1.047
3d. Current premium PMPM for 1/1/19 effective date	
(3a x 3b) x 3c	\$530.13
4. Estimated Underwriting Loss Ratio (2b/2d)	79.2%



#### **Healthcare Economics**

# WASHINGTON DC SMALL GROUP PRICING TREND DEVELOPMENT APRIL 2018 RATE FILING SUPPORT

WASHINGTON DC SMALL GROUP PRICING TREND BY COMPONENT									
	Notes:	<u>Inpatient</u>	Outpatient	Professional	<u>Other</u>	Capitation	Total <u>Medical</u>	Retail <u>Pharmacy</u>	Weighted Aggregate
Component Summary									
Utilization / Service Mix	[1],[2]	2.5%	4.2%	2.2%	-0.8%	0.0%	2.6%	5.6%	3.3%
Unit Cost	[3]	4.7%	4.6%	2.5%	0.3%	6.8%	3.7%	4.8%	3.9%
Demographic Change	[5]	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Benefit Leveraging	[4]	0.1%	0.8%	0.8%	-0.1%	0.0%	0.5%	1.2%	0.7%
<u>Margin</u>		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
<b>Total Proposed Pricing Trend</b>	[6]	7.4%	9.9%	5.6%	-0.7%	6.8%	6.9%	12.0%	8.1%
Service Weight - Washington Dc		18.4%	23.5%	26.6%	5.4%	2.5%	76.4%	23.6%	100.0%

#### Notes:

- [1] Represents core utilization only, exclusive of demographic change impacts; includes expected impact of changes in business day content.
- [2] Represents expected changes in intensity of services provided.
- [3] Represents core unit pricing increases, exclusive of service mix / intenisty of services impact;
- [4] Impact of member cost-share leveraging on net claims cost trend.
- [5] Represents trend impact of age and gender changes; No provision included for Small Group business (age/gender community rating variable).
- [6] Pricing models do not distinguish between Primary and Specialty medical care; same trends shown for both.

State: District of Columbia Filing Company: UnitedHealthcare Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other

Product Name: DC-SG-UHIC-2019-01

Project Name/Number: /

# **Supporting Document Schedules**

Satisfied - Item:	Actuarial Justification
Comments:	
Attachment(s):	DC_41842_UHIC_SG_PartIII_2019Q1_v3.pdf
Item Status:	
Status Date:	
Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	DC-SG-UHIC-ActMemo-2019-01-v4.pdf
Item Status:	
Status Date:	
Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	Actualia Memorandum and Certifications
Attachment(s):	DC_41842_UHIC_SG_PartIII_2019Q1_v3.pdf
Item Status:	DC_41042_01110_30_Faitii1_2019Q1_v3.pui
Status Date:	
Glatus Date.	
Bypassed - Item:	Certificate of Authority to File
Bypass Reason:	NA NA
Attachment(s):	
Item Status:	
Status Date:	
Bypassed - Item:	Consumer Disclosure Form
Bypass Reason:	NA
Attachment(s):	
Item Status:	
Status Date:	
Satisfied - Item:	Cover Letter All Filings
Comments:	Cotor Lottor 7 th 1 things
Attachment(s):	DC-SG-UHIC-Cover-2019-01-v2.pdf
Item Status:	DO GO GITTO GOVEL 2013 OT VZ.pdi
Status Date:	
Julius Dale.	

SERFF Tracking #:	UHLC-131461282	State Tracking #:	Co.	mpany Tracking #:
State: TOI/Sub-TOI: Product Name: Project Name/Number:	District of Columbia H16G Group Healt DC-SG-UHIC-2019 /	th - Major Medical/H16G.003G Small Gro	Filing Company: oup Only - Other	UnitedHealthcare Insurance Company
Satisfied - Item:	DIS	SB Actuarial Memorandum Datas	set	
Comments:				
Attachment(s):	DC	-SG-UHIC-ActuarialDataset-201	19-01-V5.xlsx	
Item Status:				
Status Date:				
Bypassed - Item:	Dis	strict of Columbia and Countrywic	de Experience for the Last 5	rears (P&C)
Bypass Reason:	NA			
Attachment(s):				
Item Status:				
Status Date:				
Bypassed - Item:	Dis	strict of Columbia and Countrywic	de Loss Ratio Analysis (P&C)	
Bypass Reason:	NA			
Attachment(s):				
Item Status:				
Status Date:				
Satisfied - Item:	Uni	ified Rate Review Template		
Comments:				
Attachment(s):	201	19_Unified_Rate_Review_Templ 19_Unified_Rate_Review_Templ ifiedRateReviewSubmission_UH	late_UHIC_v3.xlsm	
Item Status:				
Status Date:				
Satisfied - Item:	Dis	strict of Columbia Plain Language	e Summary	
Comments:				
Attachment(s):	DC	-SG-UHIC-PlainLanguageSumm	nary-2019-01-v3.pdf	
tem Status:				
Status Date:				
Satisfied - Item:	Rat	te Review Checklist		
Comments:				
Attachment(s):	DC	-SG-Checklist-2019-01.pdf		
Item Status:				

**Status Date:** 

SERFF Tracking #: UHLC-131461282 State Tracking #: Company Tracking #: State: District of Columbia Filing Company: UnitedHealthcare Insurance Company TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other Product Name: DC-SG-UHIC-2019-01 Project Name/Number: Satisfied - Item: **AV Screenshots** Comments: Attachment(s): AV Screenshots\_UHIC\_2019\_01.pdf **Item Status: Status Date:** Satisfied - Item: Plan Mapping Comments: Attachment(s): DC-SG-UHIC-Plan Mapping-2019-01.pdf **Item Status: Status Date:** Risk Adjustment RATEE Data Satisfied - Item: Comments: 41842.RATEE.D20180501T060434.P.xml Attachment(s): DC Confidentiality Cover Letter EDGE Data 4.25.18.pdf

Item Status: Status Date:

State: District of Columbia Filing Company: UnitedHealthcare Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other

Product Name: DC-SG-UHIC-2019-01

Project Name/Number: /

Attachment DC-SG-UHIC-ActuarialDataset-2019-01-V5.xlsx is not a PDF document and cannot be reproduced here.

Attachment 2019\_Unified\_Rate\_Review\_Template\_UHIC\_v3.xlsm is not a PDF document and cannot be reproduced here.

Attachment UnifiedRateReviewSubmission\_UHIC\_20180530153011.xml is not a PDF document and cannot be reproduced here.

Attachment 41842.RATEE.D20180501T060434.P.xml is not a PDF document and cannot be reproduced here.

# Federal Rate Filing Justification Part III Actuarial Memorandum and Certification

**UnitedHealthcare Insurance Company** 

**NAIC: 41842** 

FEIN: 362739571

**State of District of Columbia Rate Review** 

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# **Section 1: Purpose**

The following is a rate filing prepared by UnitedHealthcare Insurance Company. This filing has been prepared to provide the necessary information required by the Department of Health and Human Services and the state of District of Columbia. The purpose of this memorandum is to provide information relevant to the Federal Part I Unified Rate Review Template (URRT).

This filing establishes rates intended to be used for non-grandfathered PPACA compliant small group health benefit plans sold on the Small Business Health Options Program in District of Columbia for the 2019 plan year. A rate increase is being filed at this time. The rates and other information in this submission are based on the current regulations and guidance from HHS. Changes to this filing may be necessary if there are revisions to the regulations or updated guidance from HHS.

This memorandum is intended solely for the information of and use by the Department of Health and Human Services and the District of Columbia Department of Insurance and Financial Services. It will demonstrate compliance with state and federal laws and regulations related to the development of the index rate and allowable rating factors and is not intended to be used for any other purpose.

The attached document contains confidential, proprietary information and trade secrets. This information is strictly confidential and protected from disclosure by D.C. Code section 31-3303.08(b) and D.C. Code section 2-534(a)(1). If the prohibition against disclosure by the Department of Insurance and Financial Services is reassessed at a later date, it may not be disclosed to any other state or federal regulatory agencies unless the recipient agrees in writing prior to receipt to maintain the confidentiality of the information.

#### **Section 2: General Information**

Company Identifying Information

Company Legal Name: UnitedHealthcare Insurance Company

State: District of Columbia

HIOS Issuer ID: 41842

Market: Small Business, 1-50
Proposed Effective Date: January 01,2019

**Primary Contact Information** 

Name: Ryan Morgan, FSA, MAAA

Telephone Number: 414-443-4287

Email Address: ryan\_morgan2@uhc.com

# **Section 3: Proposed Rate Changes**

The proposed change in rates for this filing is 17.9% compared to the prior filing. These changes are applied uniformly to all plans within a rating area. The proposed pricing trend is 8.1% annually.

- Changes in medical service costs
  - Increasing Cost of Medical Services Annual increases in reimbursement rates to health care providers – such as hospitals, doctors and pharmaceutical companies.
  - Increased Utilization The number of office visits and other services continues to grow. In addition, total health care spending will vary by the intensity of care and/or use of different types of health services. Patients who are sicker generally have a higher intensity of health care utilization. The price of care can be affected by the use of expensive procedures such as surgery vs. simply monitoring or providing medications.
  - O Higher Costs from Deductible Leveraging Health care costs continue to rise every year. If deductibles and copayments remain the same, a greater percentage of health care costs need to be covered by health insurance premiums each year.
  - Cost shifting from the public to the private sector Reimbursements from the Center for Medicare and Medicaid Services (CMS) to hospitals do not generally cover all of the cost of care. The cost difference is being shifted to private health plans. Hospitals typically make up this difference by charging private health plans more.
  - O Impact of New Technology Improvements to medical technology and clinical practice often result in the use of more expensive services leading to increased health care spending and utilization.
- Administrative costs and anticipated profit
  - O UnitedHealthcare works to directly control administrative expenses by adopting better processes and technology and through the development of programs and innovations that make health care more affordable. We have led the marketplace by introducing key innovations that make health care services more accessible and affordable for customers, improve the quality and coordination of health care services, and help individuals and their physicians make more informed health care decisions.
  - O Additionally, UnitedHealthcare indirectly controls medical cost payments by using appropriate payment structures with providers and facilities. UnitedHealthcare's goal is to control costs, maximize efficiency, and work closely with physicians and providers to obtain the best value and coverage.

- O State and/or Federal government imposed taxation and fees are additional significant factors that impact health care spending. These fees include ACA taxes and fees which will have increased health insurance costs and need to be reflected in premium.
- Changes that vary by plan
  - All plan relativity factors have been updated to reflect UnitedHealthcare's most recent pricing model.
  - O The impact of any changes to plans that have occurred due to uniform modification are also reflected in the updated plan relativity factors. Please see the "Plan Adjusted Index Rate" section of the memorandum for more detail on these changes.

We refined the medical and pharmacy plan price relativities to reflect the most recent pricing methodology and pricing models. The methodology is based on UnitedHealthcare nationwide experience data, which contains utilization frequencies and unit costs by service category, in addition to claim distributions and adjustment factors for a large number of plan design variables. Benefit design parameters such as deductibles, coinsurance, copays, out-of-pocket maximums, etc. were input for each plan. The expected paid-to-allowed relativities and expected utilization differences due to differences in cost sharing for each plan are then used to develop the plan factors for each benefit plan. All benefit plans are priced consistently with each other, with the rates differing by the estimated value of the benefits and the expected utilization differences due to differences in cost sharing. The utilization differences do not reflect differences due to health status. The net impact of all changes by plan can be found in Worksheet 2, Section I of the Unified Rate Review Template.

Significant factors driving the proposed rate changes are discussed in further detail in Section 6 (*Projection Factors*) and Section 7 (*Credibility Manual Rate Development*) of this memorandum.

# **Section 4: Experience Period Premium and Claims**

#### Paid Through Date

The experience period is 1/1/2017 through 12/31/2017, with claims paid through 1/31/2018.

#### Premiums (net of MLR Rebate) in Experience Period

Earned premium for our small group market business in District of Columbia for 2017 was approximately \$46,575,800. MLR rebate payments are not anticipated in District of Columbia for the 2017 calendar year, an estimate that was provided by UnitedHealthcare's finance department. Therefore, premium net of MLR rebates and risk adjustment (payment/receivable) is \$46,835,303.

#### Support for estimate of incurred but not paid claims

Historical claims are categorized both by the month in which they were incurred and the month in which they were adjudicated. For incurral months with sufficient adjudicated claim experience, incurred claims are estimated by applying completion factors derived from the historical claims. Adjustments are made based on specific knowledge of the entity (e.g., catastrophic claims, pended claims, etc.). For incurral months where adjudicated claim experience is not sufficient to rely on completion factors, a PMPM is used to estimate incurred claims. PMPM estimates are based on expected claim seasonality patterns, monthly calendar days and work days, emerging claim trends, and other factors.

The same completion factors are applied to both incurred and allowed claims amounts.

# **Section 5: Benefit Categories**

Claims were assigned to each of the benefit categories based on where services were administered and the types of medical services rendered. The benefit categories were defined by our claims department using standard industry definitions.

#### **Inpatient Hospital**

Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.

#### **Outpatient Hospital**

Includes non-capitated facility services for surgical, emergency room, laboratory, radiology, therapeutic, observation, and other services provided in an outpatient facility setting and billed by the facility.

#### Professional

Includes non-capitated primary care, specialist care, therapeutic, the professional component of laboratory and radiology, and other professional services, other than hospital based professionals whose payments are included in facility fees.

#### Other Medical

Includes non-capitated ambulatory, home health care, durable medical equipment, prosthetics, supplies, vision exams, dental services and other services.

#### Capitation

Includes all services provided under one or more capitated agreements.

#### **Prescription Drug**

Includes drugs dispensed by a pharmacy. This amount is net of rebates received from drug manufacturers.

# **Section 6: Projection Factors**

Pricing Adjustments were made for the following factors:

#### Demographic Creep:

A morbidity adjustment of 0.5% was made for expected claim costs in 2019 compared to the experience period. The adjustment is needed to account for policies being quoted on an "issue-age" basis, where a 12-month rate is developed based on a member's age as of the effective date of the policy. The age factors do not account for aging that occurs during the policy year.

#### Trend

25 months of trend were applied to our 2017 experience to project it to the 2019 rating period. Our most recent analysis indicates annual trend in the state of District of Columbia for the 2018 and 2019 calendar years will be 7.1% and 8.1%, respectively. The table below details the components of each trend factor.

Trand Component	2018	2019	Annualized for URRT Wksh1
Trend Component	(a)	(b)	(c) = ((1+a)*(1+b))-1
Unit Cost	3.60%	3.90%	3.75%
Utilization	2.60%	3.30%	2.95%
Total	7.10%	8.10%	7.60%

UnitedHealthcare develops forward-looking medical expense estimates based on a number of considerations. In general, recent/emerging claims experience is reviewed at the market level for several broad medical expense categories (inpatient, professional, pharmacy, etc.), with utilization, unit cost, and benefit leveraging identified for each category. Future trends are developed based on a projection of each component.

Utilization rates by category are measured and projected. Forward looking utilization levels are developed based on emerging market level data, supplemented by regional and/or national level utilization data. Macroeconomic data is often used to develop assumptions regarding directional changes in national health care consumption rates. UnitedHealthcare uses same store analysis to reflect utilization. The utilization trend is adjusted by 0.4% to account for the expected change in allowed claims due to the shift in the distribution of benefit plans between the experience period and the rating period.

Market-level unit cost projections are developed based on evaluations of current and anticipated provider contract economics, as well as consideration to both current and expected changes in non-contracted provider cost exposure. Unit cost projections also consider the estimated cost impact of new technologies, service availability/mandates, or other factors that might influence the mix of procedures. Unit cost is based on our contractual changes with providers.

In addition, market-level healthcare affordability activities that are expected to impact forward-looking medical costs are recognized. Depending on the nature of individual initiatives, the impact may be recognized in one or more of the component cost items discussed above. Only incremental activities are recognized for this purpose in the expected trend impact for any particular period.

# **Section 7: Credibility Manual Rate Development**

#### Source and Appropriateness of Data Used

• The combined experience of UnitedHealthcare Insurance Company, Optimum Choice Inc, and UnitedHealthcare of Mid Atlantic in District of Columbia was used for rate development.

#### Adjustments Made to the Data

Adjustments similar to the ones described in Section 6 were applied to the experience of the credibility manual to project it to the projection period. In addition, the credibility manual was adjusted to reflect the average age, geography, plan design and morbidity of the adjusted experience period claims.

#### **Inclusion of Capitation Payments**

Capitation payments are included in both the experience and projections.

# Section 8: Credibility of Experience

The experience for this legal entity contains 106,051 member months which does not exceed the 360,000 member months needed to be considered fully credible. As such the credibility of UnitedHealthcare Insurance Company is set to 0%, and the remaining uses the credibility manual described above.

Consideration was given to ASOP #25 when determining the credibility and appropriateness of the experience and the manual rate. The manual rate is sufficiently independent from the experience and can be blended with it for purposes of rate development.

#### Section 9: Paid-to-Allowed Ratio

Paid-to-allowed ratios were developed for each plan using the proprietary UnitedHealthcare pricing model. This model uses nationwide UnitedHealthcare experience, which is fully credible. Claim data is projected to the pricing period based on national projections of utilization and unit costs. These projections are done at the service category level (inpatient, outpatient, etc.). Benefit design parameters such as deductibles, copays, and coinsurance rates are applied to the claim distributions of the matching service category. Cost sharing is applied, and the values of each service category are summed to determine an overall benefit value, or paid-to-allowed ratio. In order to preserve consistency, the same claim experience and projection assumptions are applied to all plan relativity calculations.

The average paid-to-allowed ratio is based on the paid-to-allowed ratios developed for each plan using the model discussed above and weighting them by the projected membership by plan. The member distribution is discussed under Section 21 (*Membership Projections*) of this memorandum.

# Section 10: Risk Adjustment and Reinsurance

Experience Period Risk Adjustment and Reinsurance Adjustments (PMPMs)

Risk Adjustments for the experience period are not known at this time.

Our 2017 risk adjustment transfer PMPM is estimated using data provided to UnitedHealthcare as a result of our participation in a multi-state study done by a large, independent actuarial consulting firm. Based on the results of that study, we expect that risk level of the membership insured by UnitedHealthcare Insurance Company to be lower than the market. This results in an approximate adjustment of \$2.45 PMPM.

Since this is a small group filing and the state of District of Columbia chose not to combine its individual and small group markets, reinsurance recoveries are not applicable to this rate filing. As such, no adjustments were made to the experience.

#### Projected Risk Adjustments Net of Risk Adjustment User Fees

UnitedHealthcare Insurance Company anticipates paying an average of \$2.76 PMPM for risk adjustment transfers in the state of District of Columbia for the 2019 plan year. We are assuming the risk level of our business relative to that of our competitors for the 2019 plan year will be similar to what it was in the 2017 plan year. Since risk adjustment transfer payments are a function of the market level premium, our 2019 risk adjustment transfer PMPM amount is calculated by adjusting our estimated 2017 risk adjustment transfer PMPM amount for the projected market level trend, changes in reinsurance fees and recoveries, and other adjustments based on the overall financial performance of the market. The HHS Notice of Benefit and Payment Parameters for 2019 specifies a risk adjustment user fee of \$0.15 PMPM.

The projected risk adjustment transfers net of risk adjustment user fees are therefore \$-2.91 PMPM.

#### Projected ACA Reinsurance Recoveries Net of Reinsurance Premium

The reinsurance program ended in 2016. As such, reinsurance premiums were not included in the 2019 rate development.

# Section 11: Non-Benefit Expenses and Profit

#### Administrative Expense Load

The administrative expense load is a long-term estimate of administrative expenses, including selling expenses and general administrative expenses. This load does not vary by product or plan. These assumptions are based on the general ledger actual results (GAAP) for 2017 with known adjustments. Known adjustments include, but are not limited to, pay increases/raises for employees and administrative expenses as a result of Healthcare Reform and compliance requirements. The administrative expense allocation methodology used in pricing is appropriate because it is consistent with how UnitedHealthcare runs its business and how it allocates administrative costs for Statutory Filings and the Healthcare Reform Exhibits.

#### **Profit and Risk Margin**

The profit and risk margin is shown in Worksheet 1, Section III of the URRT. This target does not vary by product or plan.

The profit and risk margin is derived from the difference between the target loss ratio and the administrative expenses, taxes and fees.

The profit and risk margin results in an anticipated MLR that is above the minimum requirements as described in the Projected Loss Ratio section.

#### Taxes and Fees

Taxes and fees are expected to be 5.3% and include premium tax, exchange fees, PCORI fees, and federal income tax. The following is a breakdown of the taxes and fees.

Premium Taxes and Fees Allocation	Estimated % of Premium
Federal / State Income Tax on Profit & Risk Load	0.8%
Premium Tax	2.0%
ACA Taxes: Insurer Fee	1.4%
ACA Taxes: Reinsurance Fee	0.0%
ACA Taxes: PCORI Fee	0.0%
ACA Taxes: Risk Adjustment User Fee	0.0%
ACA Taxes: Exchange User Fee	1.0%
All Other Taxes & Fees	0.1%
Total	5.3%

<sup>\*</sup>Marketplace user fees are applied as and adjustment to the Index Rate at the market level. The value reflects the expected mix of Marketplace and non-marketplace enrollees.

# **Section 12: Projected Loss Ratio**

The projected loss ratio using the federally prescribed MLR methodology for calendar year 2019 is 83.3%. UnitedHealthcare Insurance Company agrees to comply with the rebate requirements of 45 CFR Part 158 should the actual market MLR fall below the 80.0% requirement.

# **Section 13: Single Risk Pool**

The single risk pool reflects all covered lives for every small group non-grandfathered product and plan combination for UnitedHealthcare Insurance Company in the state of District of Columbia. It is established in accordance with the requirements of 45 CFR §156.80(d).

#### **Section 14: Index Rate**

The Index Rate for the experience period is approximately 98.52% of allowed claims due to benefits in excess of EHBs. The reported percentage amount is based on experience data. The index rate of the experience period has been reported accordingly, rounded to the nearest whole dollar value as required by the URRT. The Index Rate in the projection period represents 98.52% of allowed claims due to the benefits in excess of EHBs.

#### Small Group Trend Adjustment

We are proposing premium rates that trend by quarter. The trend assumption only includes unit cost and utilization trend as this calculation is on an allowed basis.

	Q1	Q2	Q3	Q4	Average
CY 2019 Index Rate	\$ 467.89	\$ 467.89	\$ 467.89	\$ 467.89	\$ 467.89
Average Quarterly Trend	1.003	1.024	1.043	1.065	1.037
Quarterly Index Rate	\$ 469.43	\$ 479.22	\$ 487.78	\$ 498.11	\$ 485.29
Member Months	28,654	17,749	19,609	40,039	106,051

# **Section 15: Market Adjusted Index Rate**

The market adjusted index rate includes market-wide adjustments for the risk adjustment program and exchange user fees. Please refer to Section 10 (*Risk Adjustment*) and Section 11 (*Non-Benefit Expenses and Profit*) of this memorandum for a brief description of each of these items. Incurred values were grossed up by the average paid-to-allowed ratio to reflect an allowed basis.

Index Rate	Net Risk Adjustment (allowed basis)	Exchange Fee Adjustment (allowed basis)	Market Adjusted Index Rate	
\$485.29	\$3.33	\$6.04	\$494.65	

The figures above may not tally exactly due to rounding of the display.

# **Section 16: Plan Adjusted Index Rates**

The development of the projected index rate and all rating factors is in compliance with all applicable federal statutes and regulations (45 CFR 156.80 and 147.102)

#### Actuarial Value and Cost Sharing Adjustment

UnitedHealthcare has a proprietary pricing model that was used in developing the actuarial value and cost sharing adjustment for each plan. The model calculates plan relativity factors for medical and pharmacy benefits. Also included under the actuarial value and cost sharing adjustment are adjustments for leveraging and the difference between the average plan relativity factor and the projected paid to allowed ratio.

UnitedHealthcare Insurance Company does not utilize Induced Demand factors in our rate development. Instead, our plan-specific pricing factors are based on an analysis of UnitedHealthcare Insurance Company's nationwide block of Small Group health insurance, which reflects over 10 million member months of experience. Our approach complies with the prohibition of rating for morbidity differences by normalizing out the cost differences attributable to morbidity as measured by HHS's risk adjustment mechanism.

Historical UnitedHealthcare experience was used to develop the actuarial value and cost sharing adjustment.

#### Provider network, delivery system and utilization management adjustment

Any adjustments for these items are included in the plan relativity factors.

#### Benefits in Addition to EHBs

The Index Rate for the experience period is approximately 98.52% of allowed claims due to benefits in excess of EHBs. The reported percentage amount is based on experience data. The index rate of the experience period has been reported accordingly, rounded to the nearest whole dollar value as required by the URRT. The Index Rate in the projection period represents 98.52% of allowed claims due to the benefits in excess of EHBs.

#### **Distribution and Administrative Costs**

Distribution and administrative costs include premium tax, PCORI fees, SG&A, quality improvements, federal income tax, and after-tax income. These items were previously discussed in Section 11 (*Non-Benefit Expenses and Profit*) of this memorandum. Risk adjustment transfers and user fees and exchange fees are excluded because they are accounted for in the market adjusted index rate.

#### Section 17: Calibration

Plan Adjusted Index Rates need to be calibrated to apply the allowable rating factors of age and geography in order to calculate the Consumer Adjusted Premium Rates. Calibration factors are applied uniformly to all plans.

#### **Age Calibration**

The calculated age curve calibration is 1.049, which equals the average age factor of the expected member distribution by age. This corresponds with an approximate age of 41 years. The age factors used in this calculation are the HHS-specified age curve.

#### **Geographic Calibration**

The geographic factor calibration is 1, which equals the expected average area factor. A table of the geographic rating factors is below.

Rating Area	Area Factor
1	1.000

Geographic rating factors are reviewed periodically versus UnitedHealthcare claims data that reflects unit cost differences by county. Such a review was conducted as part of our January 1, 2019 rate development.

Our analysis did not indicate that there were credible, material differences indicated by the comparison of currently approved area factors and the UHC data reflecting unit cost differences.

Population morbidity by area was not considered when determining geographic area factors.

Calibrating the plan adjusted index rate to the age curve and geographic distribution results in the calibrated premium rate for each plan. The calibrated premium rate represents the preliminary premium rate charged to an individual before applying the consumer specific rating adjustments for age and area.

#### **Tobacco Calibration**

Tobacco factors are not used in the rating of these products, and no calibration is needed.

## **Section 18: Consumer Adjusted Premium Rate Development**

The consumer adjusted premium rate is the final premium rate that is charged to an individual. It is developed by calibrating the plan adjusted index rate by the average age and geographic rating factors, and applying the consumer specific age and geographic rating factors. The calculation is provided below.

Plan Adjusted Index Rate

/ Age Calibration Factor

/ Geographic Calibration Factor

- \* Consumer Specific Age Rating Factor
- \* Consumer Specific Geographic Rating Factor
- \* Small Group Trend Adjustment
- =Consumer Adjusted Premium Rate

## **Small Group Trend Adjustment**

Since this is a small group filing that includes rates with scheduled trend increases by quarter, the Index Rate, Market Adjusted Index Rate and Plan Adjusted Index Rate reflect the member weighted average premium over the calendar year. As such, the Consumer Adjusted Premium Rate needs to include a trend adjustment specific to the quarter for which the rates are being calculated. The trend factors used to develop the consumer adjusted premium rates are shown below.

	Quarterly Trend	Average Trend	Trend Adjustment
	(a)	(b)	(a) / (b)
Q1	1.01	1.041	0.970
Q2	1.03	1.041	0.990
Q3	1.05	1.041	1.009
Q4	1.071	1.041	1.029

## Section 19: AV Metal Values

The AV calculator used to calculate the AV metal values is based on a prescribed methodology and, therefore, does not necessarily reflect a reasonable estimate of the portion of allowed costs covered by the associated plan. Please refer to Section 9 (*Paid-to-Allowed Ratio*) of this memorandum for further detail regarding our estimate of the portion of allowed costs covered by each plan.

Some plans within this portfolio have cost sharing features that differ between individual and family coverage (i.e., when two or more people are covered by the plan). For all plans, consistent with the Actuarial Value Calculator inputs, we have used only the cost sharing provisions applicable for individuals in the actuarial value calculation.

The AV calculator was used to determine the AV metal values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans. Some of our plan designs are not directly compatible with the AV calculator. The values were developed in accordance with generally accepted actuarial principles and methodologies. Additional details are provided below to describe the types of adjustments that were made for plan designs that are not directly compatible with the AV calculator.

#### Copays Paid in Conjunction with Coinsurance

Some of our plan designs include copays that are paid in conjunction with coinsurance in the coinsurance range. This benefit design is not directly compatible with the AV calculator, so the alternate methodology described in 45 CFR 156.135(b)(2) was used for the AV calculation. In order to modify the AV calculator input for a copay paid in conjunction with coinsurance, the following formula was used to estimate the insurer's cost share.

Effective Insurer Coinsurance Rate = (1 – Member Copay/Average Unit Cost) \* (1-Member Coinsurance Rate)

The benefit was then marked as "Subject to Deductible" and "Subject to Coinsurance" with a "Coinsurance, if different" equal to the effective insurer coinsurance rate as calculated above. The copay was entered in the "Copay if separate" column.

The average unit cost was calculated based on the claims data included within the AV calculator continuance tables for each metal level. For example, if the plan was expected to fall within a Silver Metal Tier, the average unit cost was calculated from the Silver continuance tables. All enrollees within a continuance table whose claims exceeded \$1,500 were included in the calculation of the average unit cost for each benefit type.

#### Benefits that Vary Based on Place of Service

For some types of services, our plan designs include different benefit levels based on the place of service (i.e. physician's office, free standing facility, or outpatient hospital facility). To incorporate this differentiation in benefits, the Tiered Network Option was selected within the AV calculator, and utilization was assigned to each tier based on historical experience of affiliated carriers.

#### **HRA Contributions**

Plan designs with HRA contributions of \$X apply to the member's final \$X of their deductible. To calculate a final AV, an adjustment was applied to the results of an AV run where the employer HRA contribution was \$0. The adjustment was equal to the difference in AV of runs where (1) the employer HRA contribution was equal to the deductible and (2) the employer contribution was equal to the deductible minus \$X.

#### **Physician Tiering**

Select plan designs include lower cost sharing when members utilize providers we designate as meeting cost and efficiency standards. The tiered network functionality of the AV calculator was utilized to account for the cost sharing differences. The utilization of providers was based on a UnitedHealthcare study of differences in cost sharing and their effectiveness at driving utilization patterns.

## Per Occurrence Copays

Select plan designs have per occurrence copays where a copay is paid before coinsurance is applied between the deductible and maximum out of pocket. These copays accumulate to the maximum out of pocket. To reflect this type of benefit an effective insurer coinsurance rate was calculated based on the average unit cost of the service and member coinsurance rate. The calculation is as follows:

Effective Insurer Coinsurance Rate = (1 – Member Copay/Average Unit Cost) \* (1-Member Coinsurance Rate)

Some of the copays only apply to portions of the benefit categories that the AV calculator defines. For example, the Inpatient Hospital Services includes both physician and facility charges. To the extent the plan design per occurrence copay only applies to a portion of the services, the tiered Network functionality was utilized. The mix of services within the AV calculator benefit categories was based on historical experience.

The average unit cost was calculated based on the claims data included within the AV calculator continuance tables for each metal level where available.

## **Section 20: AV Pricing Values**

The AV pricing values represent the cumulative effect of adjustments made by the issuer to move from the market adjusted index rate to the plan adjusted index rate. Each of the allowable modifiers to move from the market adjusted index rate to the plan adjusted index rate was previously discussed in Section 16 (*Plan Adjusted Index Rates*) of this memorandum.

## **Section 21: Membership Projections**

The 2019 plan year membership projection was developed utilizing the experience period plan level membership distribution along with sales and persistency targets. Member distribution by plan was then based on current enrollment, taking into consideration changes in the portfolio of plans to be offered in 2019. Strictly for purposes of the URRT, we have projected membership by plan.

## **Section 22: Terminated Products**

There are no products being terminated in this rate filing.

Some plans are being terminated as of the end of 2018. See the appendix for a list of terminated plans. The terminated plans, if any, are not being mapped to specific plans. Rather, at renewal, employers are given the option to select from multiple plans.

## Section 23: Plan Type

A plan type of EPO & POS has been selected, which describes the plans exactly.

## **Section 24: Warning Alerts**

There are no warning alerts on Worksheet 2 of the URRT.

## Section 25: Reliance

Due to responsibility allocation, I have relied upon other individuals within the UnitedHealthcare organization to provide certain assumptions. Although I have performed a limited review of the information and have not found it unreasonable or inconsistent, I have not reviewed it in enough detail to fully judge the reasonableness of the information due to the substantial amount of additional time required. I have therefore relied upon the expertise of those individuals who have developed the assumptions, and am providing the information required by Actuarial Standard of Practice 41, section 4.3. A list of reliances is included below.

## <u>UnitedHealthcare Finance Department</u>

- Projected SG&A Assumption
- Total Projected Membership

## <u>UnitedHealthcare National Pricing Team</u>

• Plan Relativity Modeling

## UnitedHealthcare Healthcare Economics Department

- Projected Trend
- Estimates of Incurred but not Paid Claims
  - ACO/Premium Designated Provider
- Cost Savings Estimates
- Plan Relativity Modeling

## **Section 26: Actuarial Certification**

I, Ryan Morgan, FSA, MAAA, am a Director, Actuarial Services for UnitedHealthcare, and a member of the American Academy of Actuaries. I meet the Academy's qualification standards for rendering statements of actuarial opinion with respect to the filing of rates for health insurance products.

To the best of my knowledge and judgment, I certify that:

- The projected index rate is:
  - In compliance with state and federal statutes and regulations related to the development of the index rate and allowable rating factors (such as 45 CFR 156.80 and 147.102).
  - Developed in compliance with the applicable Actuarial Standards of Practice.
  - Reasonable in relation to the benefits provided and population anticipated to be covered.
  - Neither excessive, deficient, nor unfairly discriminatory.
- The index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CRF 156.80(d)(2) were used to generate plan level rates.
- The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.
- The geographic rating factors reflect only differences in the costs of delivery and do not include differences for population morbidity by geographic area.
- The AV calculator was used to determine the AV metal values shown in Worksheet 2 of the Part I Unified
  Rate Review Template for all plans. Some of our plan designs are not directly compatible with the AV
  calculator. The values were developed in accordance with generally accepted actuarial principles and
  methodologies. The unique plan design actuarial certification required by 45 CFR Part 156.135.
- The Part I Unified Rate Review Template does not demonstrate the process used by the issuer to
  develop their rates. Rather, it represents information required by federal regulation to be provided in
  support of the review of rate increases, for certification of qualified health plans for federally facilitated
  exchanges, and for certification that the index rate is developed in accordance with federal regulation
  and used consistently and only adjusted by the allowable modifiers.

Ryan Morgan	5/31/2018
Ryan Morgan, FSA, MAAA	Date
Director, Actuarial Services	

## Actuarial Memorandum UnitedHealthcare Insurance Company, NAIC #79413 DC Small Group Rate Filing

June 1, 2018

This rate filing presents proposed premium rates effective January 1, 2019 through December 31, 2019 for medical and Rx benefit plans to be sold by the UnitedHealthcare Insurance Company to small group employers.

The filing has been prepared as required by the "Reasonable Health Insurance Ratemaking and Health Care Reform Act of 2010", as well as current ACA rules and more recent guidance from the DC Department of Insurance. This rate filing should not be used for any other purposes. Within that context, there are no limitations or constraints on the use or applicability of the rating items discussed herein. The intended user of this filing is the DC Department of Insurance.

The benefit plans and rates are for non-grandfathered employers. The proposed rates and rate factors are in Exhibit 1, which also displays the metal level and actuarial value of each benefit plan. Benefit plan descriptions are in Exhibit 2. Exhibit 4 identifies new benefit plans being added in 2019, and 2018 benefit plans with plan changes (uniform modification).

Responding to the items in the DC Rate Filing Checklist:

1. Purpose of Filing. UnitedHealthcare is filing for the first time rates for 2019. The proposed 1st quarter 2019 rates are on average 16.1% higher than our 1st quarter 2018 rates. The rate changes vary by benefit plan as we have realigned our price relationships between plans. In addition, we are filing for quarterly rate increases as follows: 2Q19 +2.6%, 3Q19 +2.6%, 4Q19 +2.7%. These quarterly rate increases are based on the combination of our trend rate of 8.4% and the phasing back in of ACA fees, which are suspended for 2019, but are expected to return in 2020. The average year-over-year renewal rate change is +17.9%, the minimum change on this entity is +11.0%, and the maximum change on this entity is +30.7%. Please see Exhibit 3 for detail on the rate changes.

2) Form Numbers. The form numbers are as follows: POL19.SHOP.I.2018.SG.DC, COC19.SHOP.I.2018.SG.DC, SBN.CHP.I.2018.SG.DC.PL1, SBN.CHP.I.2018.SG.DC.PL4, SBN.CHP.I.2018.SG.DC.PL14, SBN19.CHP.I.2018.SG.DC.GO1, SBN19.CHP.I.2018.SG.DC.GO7, SBN19.CHP.I.2018.SG.DC.GO8, SBN19.CHP.I.2018.SG.DC.GO10. SBN19.CHP.I.2018.SG.DC.GO13. SBN19.CHP.I.2018.SG.DC.GO22, SBN19.CHP.I.2018.SG.DC.GO23. SBN19.CHP.I.2018.SG.DC.GO26, SBN19.CHP.I.2018.SG.DC.SL8, SBN19.CHP.I.2018.SG.DC.SL11, SBN19.CHP.I.2018.SG.DC.SL18, SBN19.CHC.I.2018.SG.DC.PL1, SBN19.CHC.I.2018.SG.DC.PL4, SBN19.CHC.I.2018.SG.DC.GO1, SBN19.CHC.I.2018.SG.DC.GO8, SBN19.CHC.I.2018.SG.DC.GO13, SBN19.CHC.I.2018.SG.DC.GO22, SBN19.CHC.I.2018.SG.DC.GO23, SBN19.CHC.I.2018.SG.DC.GO26, SBN19.CHC.I.2018.SG.DC.SL8, SBN19.CHC.I.2018.SG.DC.SL11, SBN19.CHC.I.2018.SG.DC.SL18, SBN19.CHC.I.2018.SG.DC.BR4, RID19.PDS.NET.I.2018.SG.DC, RID19.PDS.NET-OON.I.2018.SG.DC, RID19.PVCS.NET.I.2018.SG.DC, RID19.PVCS.NET-OON.I.2018.SG.DC, RID19.RX.NET.I.2018.SG.DC, RID19.RX.NET-OON.I.2018.SG.DC, SBN19.RX.NET.I.2018.SG.DC.54075, SBN19.RX.NET.I.2018.SG.DC.104075, SBN19.RX.NET.I.2018.SG.DC.152550, SBN19.RX.NET.I.2018.SG.DC.1050100150, SBN19.RX.NET.I.2018.SG.DC.NONE, SBN19.RX.NET-OON.I.2018.SG.DC.54075,

SBN19.RX.NET-OON.I.2018.SG.DC.104075, SBN19.RX.NET-OON.I.2018.SG.DC.152550, SBN19.RX.NET-OON.I.2018.SG.DC.1050100150

- 3) HIOS Product ID. The HIOS product ID's for the respective products are as follows: CH+/Ins (POS): 41842DC001 and CH/Ins (EPO): 41842DC004
- 4) Effective Date. 1/1/2019.
- 5) Market. The benefit plans will be offered in the small employer group market.
- <u>6) Status of Forms</u>. The forms are open to new sales and are for non-grandfathered groups.
- 7) Benefits/Metal Levels. The benefits by plan are summarized in Exhibit 2. The metal level for each benefit plan is indicated in Exhibit 1.
- <u>7.1) AV Value</u>. The actuarial value for each plan design using the HHS provided AV calculator is indicated in Exhibit 1. For plan designs that do not fit into the AV calculator, certification of the methodology and input used is in Exhibit B.
- 8) Average Rate Increase Requested (Across all legal entities)

#### Incremental:

1Q19/4Q18: +10.3% 2Q19/1Q19: +2.6% 3Q19/2Q19: +2.6% 4Q19/3Q19: +2.7%

## Year-over-year renewal:

1Q19/1Q18: +16.1% 2Q19/2Q18: +17.2% 3Q19/3Q18: +18.3% 4Q19/4Q18: +19.4%

Average year-over-year renewal: +17.9%

9) Maximum Rate Increase Requested (Specific to UHC)

## Incremental:

1Q19/4Q18: +20.8% 2Q19/1Q19: +2.6% 3Q19/2Q19: +2.6% 4Q19/3Q19: +2.7%

Year-over-year renewal: +30.7%

10) Minimum Rate Increase Requested (Specific to UHC)

#### Incremental:

1Q19/4Q18: +5.4% 2Q19/1Q19: +2.6% 3Q19/2Q19: +2.6% 4Q19/3Q19: +2.7%

Year-over-year renewal: +11.0%

- 11) Absolute Maximum Premium Increase. The absolute maximum year-over-year renewal increase, including one year of aging (20 to 21, which is an 11.1% increase in age factor), is +45.2%.
- $\underline{12}$ ) Average Renewal Rate Increase for a Year. The average renewal rate change by HIOS product ID is: 41842DC001 + 19.8%, 41842DC004 + 24.6%.

## 13) Rate Change History.

10/1/18: +1.7% 7/1/18: +1.8% 4/1/18: +1.7% 1/1/18: -3.0% 10/1/17: +2.6% 7/1/17: +2.5% 4/1/17: +2.5% 1/1/17: -5.7% 10/1/16: +1.9% 7/1/16: -3.2% 4/1/16: +5.0%

14) Exposure. As of January, 2018:

Policies: 1,218 Certificates: 5,709 Covered Lives: 9,777

15) Member Months. See Exhibit A.

16) Past Experience. See Exhibit A.

17) Index Rate. \$485.29

## 17.1) Rate Development.

The base experience is shown in Exhibit A.

We are proposing to set our 1<sup>st</sup> quarter 2019 on average 10.3% higher than our current 4<sup>th</sup> quarter 2018 rates, and then apply quarterly rate increases in each of the last three quarters of 2019. The quarterly rate increases are equivalent to an annual 8.1% trend rate plus the impact of phasing back in the ACA fees. As shown in Exhibit D, our analysis indicates that these rates will yield a 79.2% underwriting loss ratio (claims divided by premium which includes PPACA fees).

The 2019 base rate of 700.68 is calculated as follows: (2018 Base Rate) x (Trend) x (Revenue Neutral Base Rate Adjustment) x (1/1/2019 Rate Change) 2019 Base Rate = (\$605.35) x (1.071) x (0.997) x (1.084) = \$700.68

- 18) Credibility Assumption. We have set our rate levels based on the combined DC experience on our small group licenses, which we believe is credible.
- 19) Trend Assumption. See Exhibit T. At UnitedHealthcare, we have a team of actuaries whose responsibilities include developing forward-looking trend projections and monitoring historical performance in relation to trend. We rely on this team to provide guidance on trends appropriate for DC rate development.

- 20) Cost Sharing Changes and 21) Benefit Changes. Changes to member cost sharing were required for certain benefit plans. Use of the new federal Actuarial Value (AV) Calculator led to some benefit plans falling outside the allowed +2% /-4% AV metal ranges. Benefit plan changes were made to move these plans back into the allowed AV ranges. The benefit changes for these plans, and the estimated cost value of the changes, is shown in Exhibit 4.
- 22) Plan Relativities. We refined the medical plan price relativities to reflect the most recent methodology update using the most recent available models. The medical plan price relativities were developed using our pricing model ARC (Actuarial Relativity Calculator). The ARC model is based on UnitedHealthcare nationwide experience data, containing utilization frequencies and unit costs by service category, and claim distributions and adjustment factors for a large number of plan design variables. Benefit design parameters such as deductibles, coinsurance, copays, out-of-pocket maximums, etc. were input for each plan into ARC. The expected net-to-allowed relativity for each plan is then used to develop the plan relativities for each benefit plan. All benefit plans are priced consistently with each other, with the rates different only by the estimated value of the benefit differences. The prescription drug plan relativities were similarly developed using our ARC Pricing model: this model, based on nationwide UnitedHealthcare prescription drug experience, values the cost differences of Rx copays by tier, and other plan cost sharing features such as Rx deductibles and coinsurance.

Using the new ARC model (used for both medical and Rx price relativities), we set the new 2019Q1 base rates to be 0.3% lower, using our 2017 membership by benefit plan as weights, than the 2018Q1 rates. This is demonstrated in Exhibit 6.

- <u>23)</u> Rating Factors. We are resetting our 1<sup>st</sup> quarter 2019 Effective Date Adjustment (EDA) factors to 1.000. Rating factors are displayed on Exhibit 1. Exhibit 3 details the changes to rating factors.
- 23.1) Wellness Programs. No wellness programs are included in this rate filing.
- <u>24) Distribution of Rate Increases</u>. The distribution of rate increases is shown in the DISB Actuarial Memorandum Dataset.
- 25) Claim Reserve Needs. The incurred period used for the base period is 1/1/17 through 12/31/17, using claims paid through January, 2018. The claim reserve amounts are included in Exhibit A. A description of our reserving methodology is included in the Part III Actuarial Memorandum.
- <u>26) Administrative Costs of Programs that Improve Health Care Quality</u>. The Improving Health Care Quality costs in total for our small group licenses is 0.9% of premium.
- <u>27) Taxes and Licensing or Regulatory Fees</u>. The amount of taxes, licenses, and fees subtracted from premium in the denominator of the medical loss ratio calculation is 4.1%. Differences from amounts in the Supplemental Health Care Exhibit are due to different amounts of PPACA fees by year, and different Federal Income Taxes due to different underwriting loss ratios.
- 28) Medical Loss Ratio (MLR). The anticipated Federal MLR is 83.3%, which is greater than the 80% minimum. The estimated Federal MLR components, adjustments, and formula are as follows:
  - 79.2% Underwriting loss ratio
  - 0.9% QI/HIT Medical costs added
  - 4.1 % Taxes, regulatory fees and assessments

MLR formula:  $[(UW LR) \times (1 + QIT)]/(1 - taxes)$ 

- <u>29) Risk Adjustment</u>. Based on analysis done in conjunction with a national actuarial consulting firm, we estimate we will be a 0.7% risk payer in total for our small group licenses, this is assumed in the underwriting loss ratio development.
- 30) Past and Prospective Loss Experience Within and Outside the State. Only loss experience on DC plans, written on DC employers, was used in the development of the rates. This experience does include medical services provided outside DC, to employees of DC employers who live outside DC, or to DC residents who obtain medical services outside DC. We have set our rate levels based on the total overall experience of our small group licenses in DC, which we believe is credible, thus not requiring use of loss experience outside the state.
- 31) A Reasonable Margin for Reserve Needs. The profit margin assumed in the development of the proposed rates is 3.0% of premium. This assumption was derived as: 100% projected underwriting loss ratio projected expenses (including PPACA fees) as % of premium projected taxes (including FIT) as % of premium. This methodology has not changed from prior filings.
- 32) Past and Prospective Expenses. The expenses assumed in the development of the proposed rates are as follows. These are the total average expenses for the small group licenses. Except for difference in PPACA fees which vary by calendar year, they are forecasted 2018 year expenses that are expected to continue in the future.

% of Premium	Expense Category
3.0%	Salaries, wages, employment taxes, and other employee benefits
6.2%	Commissions
4.1%	Taxes, licenses, and other regulatory fees
1.6%	Cost containment programs / quality improvement activities
2.9%	All other administrative expenses
17.8%	Total

- 33) Any Other Relevant Factors Within and Outside the State. None.
- 34) Other. None.
- 35) Actuarial Certification.
- I, Ryan Morgan, a Director at UnitedHealthcare, am an FSA and MAAA. I satisfy the 2017 continuing professional development requirements of the Academy and therefore am qualified to issue this 2018 statement of actuarial opinion. I have reviewed applicable ASOPs during the preparation of this rate filing. There are no known cautions with regard to risk or uncertainty in the items discussed in this rate filing. There are no conflicts of interest with regards to my production of this rate filing.

I certify that the anticipated loss ratio meets the minimum requirement, the rates are reasonable in relation to benefits, the filing complies with the laws and regulations of DC and all applicable Actuarial Standards of Practice, including ASOP No. 8, and the rates are not unfairly discriminatory.

Ryan Morgan

Ryan Morgan, FSA, MAAA

Date: 6/1/2018

- 36) Part I Preliminary Justification for Grandfathered Plan Filings. Not applicable.
- 36.1) Unified Rate Review Template. This is provided via SERFF.
- 37) Part II Preliminary Justification. This is provided via SERFF.
- 38) DISB Actuarial Memorandum Dataset. This is provided via SERFF.
- 39) DC Plain Language Summary. This is provided via SERFF.
- 40) Summary of Components for Requested Rate Change: Please see Exhibit 3.
- 41) CCIIO Risk Adjustment Transfer Elements Extract (RATE 'E'): This was provided via SERFF.
- 42) Additional Requirements for Stand-Alone Dental Plans. Not applicable.

## <u>List of exhibits included in rate filing</u>:

Exhibit 1: Rates and rate factors.

Exhibit 2: Benefit plan descriptions.

Exhibit 3: Rate factor changes.

Exhibit 4: Rating example.

Exhibit A: Member months, earned premium & incurred claim experience.

Exhibit B: Certification for AV calculator.

Exhibit C: PPACA fees & development of fee EDA factors by quarter.

Exhibit D: Development of underwriting loss ratio.

Exhibit T: Trend assumptions and development.

Please keep these rates confidential to the extent allowed by DC law.

If you have questions, or need any further information, please do not hesitate to contact me.

Sincerely,

Ryan Morgan, FSA, MAAA Director, Actuarial Services

Kyan Morgan

UnitedHealthcare

# Federal Rate Filing Justification Part III Actuarial Memorandum and Certification

**UnitedHealthcare Insurance Company** 

**NAIC: 41842** 

FEIN: 362739571

**State of District of Columbia Rate Review** 

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## **Section 1: Purpose**

The following is a rate filing prepared by UnitedHealthcare Insurance Company. This filing has been prepared to provide the necessary information required by the Department of Health and Human Services and the state of District of Columbia. The purpose of this memorandum is to provide information relevant to the Federal Part I Unified Rate Review Template (URRT).

This filing establishes rates intended to be used for non-grandfathered PPACA compliant small group health benefit plans sold on the Small Business Health Options Program in District of Columbia for the 2019 plan year. A rate increase is being filed at this time. The rates and other information in this submission are based on the current regulations and guidance from HHS. Changes to this filing may be necessary if there are revisions to the regulations or updated guidance from HHS.

This memorandum is intended solely for the information of and use by the Department of Health and Human Services and the District of Columbia Department of Insurance and Financial Services. It will demonstrate compliance with state and federal laws and regulations related to the development of the index rate and allowable rating factors and is not intended to be used for any other purpose.

The attached document contains confidential, proprietary information and trade secrets. This information is strictly confidential and protected from disclosure by D.C. Code section 31-3303.08(b) and D.C. Code section 2-534(a)(1). If the prohibition against disclosure by the Department of Insurance and Financial Services is reassessed at a later date, it may not be disclosed to any other state or federal regulatory agencies unless the recipient agrees in writing prior to receipt to maintain the confidentiality of the information.

## **Section 2: General Information**

Company Identifying Information

Company Legal Name: UnitedHealthcare Insurance Company

State: District of Columbia

HIOS Issuer ID: 41842

Market: Small Business, 1-50
Proposed Effective Date: January 01,2019

**Primary Contact Information** 

Name: Ryan Morgan, FSA, MAAA

Telephone Number: 414-443-4287

Email Address: ryan\_morgan2@uhc.com

## **Section 3: Proposed Rate Changes**

The proposed change in rates for this filing is 17.9% compared to the prior filing. These changes are applied uniformly to all plans within a rating area. The proposed pricing trend is 8.1% annually.

- Changes in medical service costs
  - Increasing Cost of Medical Services Annual increases in reimbursement rates to health care providers – such as hospitals, doctors and pharmaceutical companies.
  - Increased Utilization The number of office visits and other services continues to grow. In addition, total health care spending will vary by the intensity of care and/or use of different types of health services. Patients who are sicker generally have a higher intensity of health care utilization. The price of care can be affected by the use of expensive procedures such as surgery vs. simply monitoring or providing medications.
  - O Higher Costs from Deductible Leveraging Health care costs continue to rise every year. If deductibles and copayments remain the same, a greater percentage of health care costs need to be covered by health insurance premiums each year.
  - Cost shifting from the public to the private sector Reimbursements from the Center for Medicare and Medicaid Services (CMS) to hospitals do not generally cover all of the cost of care. The cost difference is being shifted to private health plans. Hospitals typically make up this difference by charging private health plans more.
  - O Impact of New Technology Improvements to medical technology and clinical practice often result in the use of more expensive services leading to increased health care spending and utilization.
- Administrative costs and anticipated profit
  - O UnitedHealthcare works to directly control administrative expenses by adopting better processes and technology and through the development of programs and innovations that make health care more affordable. We have led the marketplace by introducing key innovations that make health care services more accessible and affordable for customers, improve the quality and coordination of health care services, and help individuals and their physicians make more informed health care decisions.
  - O Additionally, UnitedHealthcare indirectly controls medical cost payments by using appropriate payment structures with providers and facilities. UnitedHealthcare's goal is to control costs, maximize efficiency, and work closely with physicians and providers to obtain the best value and coverage.

- O State and/or Federal government imposed taxation and fees are additional significant factors that impact health care spending. These fees include ACA taxes and fees which will have increased health insurance costs and need to be reflected in premium.
- Changes that vary by plan
  - All plan relativity factors have been updated to reflect UnitedHealthcare's most recent pricing model.
  - O The impact of any changes to plans that have occurred due to uniform modification are also reflected in the updated plan relativity factors. Please see the "Plan Adjusted Index Rate" section of the memorandum for more detail on these changes.

We refined the medical and pharmacy plan price relativities to reflect the most recent pricing methodology and pricing models. The methodology is based on UnitedHealthcare nationwide experience data, which contains utilization frequencies and unit costs by service category, in addition to claim distributions and adjustment factors for a large number of plan design variables. Benefit design parameters such as deductibles, coinsurance, copays, out-of-pocket maximums, etc. were input for each plan. The expected paid-to-allowed relativities and expected utilization differences due to differences in cost sharing for each plan are then used to develop the plan factors for each benefit plan. All benefit plans are priced consistently with each other, with the rates differing by the estimated value of the benefits and the expected utilization differences due to differences in cost sharing. The utilization differences do not reflect differences due to health status. The net impact of all changes by plan can be found in Worksheet 2, Section I of the Unified Rate Review Template.

Significant factors driving the proposed rate changes are discussed in further detail in Section 6 (*Projection Factors*) and Section 7 (*Credibility Manual Rate Development*) of this memorandum.

## **Section 4: Experience Period Premium and Claims**

## Paid Through Date

The experience period is 1/1/2017 through 12/31/2017, with claims paid through 1/31/2018.

### Premiums (net of MLR Rebate) in Experience Period

Earned premium for our small group market business in District of Columbia for 2017 was approximately \$46,575,800. MLR rebate payments are not anticipated in District of Columbia for the 2017 calendar year, an estimate that was provided by UnitedHealthcare's finance department. Therefore, premium net of MLR rebates and risk adjustment (payment/receivable) is \$46,835,303.

## Support for estimate of incurred but not paid claims

Historical claims are categorized both by the month in which they were incurred and the month in which they were adjudicated. For incurral months with sufficient adjudicated claim experience, incurred claims are estimated by applying completion factors derived from the historical claims. Adjustments are made based on specific knowledge of the entity (e.g., catastrophic claims, pended claims, etc.). For incurral months where adjudicated claim experience is not sufficient to rely on completion factors, a PMPM is used to estimate incurred claims. PMPM estimates are based on expected claim seasonality patterns, monthly calendar days and work days, emerging claim trends, and other factors.

The same completion factors are applied to both incurred and allowed claims amounts.

## **Section 5: Benefit Categories**

Claims were assigned to each of the benefit categories based on where services were administered and the types of medical services rendered. The benefit categories were defined by our claims department using standard industry definitions.

#### **Inpatient Hospital**

Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.

## **Outpatient Hospital**

Includes non-capitated facility services for surgical, emergency room, laboratory, radiology, therapeutic, observation, and other services provided in an outpatient facility setting and billed by the facility.

## Professional

Includes non-capitated primary care, specialist care, therapeutic, the professional component of laboratory and radiology, and other professional services, other than hospital based professionals whose payments are included in facility fees.

#### Other Medical

Includes non-capitated ambulatory, home health care, durable medical equipment, prosthetics, supplies, vision exams, dental services and other services.

#### Capitation

Includes all services provided under one or more capitated agreements.

## **Prescription Drug**

Includes drugs dispensed by a pharmacy. This amount is net of rebates received from drug manufacturers.

## **Section 6: Projection Factors**

Pricing Adjustments were made for the following factors:

#### Demographic Creep:

A morbidity adjustment of 0.5% was made for expected claim costs in 2019 compared to the experience period. The adjustment is needed to account for policies being quoted on an "issue-age" basis, where a 12-month rate is developed based on a member's age as of the effective date of the policy. The age factors do not account for aging that occurs during the policy year.

#### Trend

25 months of trend were applied to our 2017 experience to project it to the 2019 rating period. Our most recent analysis indicates annual trend in the state of District of Columbia for the 2018 and 2019 calendar years will be 7.1% and 8.1%, respectively. The table below details the components of each trend factor.

Trand Component	2018	2019	Annualized for URRT Wksh1
Trend Component	(a)	(b)	(c) = ((1+a)*(1+b))-1
Unit Cost	3.60%	3.90%	3.75%
Utilization	2.60%	3.30%	2.95%
Total	7.10%	8.10%	7.60%

UnitedHealthcare develops forward-looking medical expense estimates based on a number of considerations. In general, recent/emerging claims experience is reviewed at the market level for several broad medical expense categories (inpatient, professional, pharmacy, etc.), with utilization, unit cost, and benefit leveraging identified for each category. Future trends are developed based on a projection of each component.

Utilization rates by category are measured and projected. Forward looking utilization levels are developed based on emerging market level data, supplemented by regional and/or national level utilization data. Macroeconomic data is often used to develop assumptions regarding directional changes in national health care consumption rates. UnitedHealthcare uses same store analysis to reflect utilization. The utilization trend is adjusted by 0.4% to account for the expected change in allowed claims due to the shift in the distribution of benefit plans between the experience period and the rating period.

Market-level unit cost projections are developed based on evaluations of current and anticipated provider contract economics, as well as consideration to both current and expected changes in non-contracted provider cost exposure. Unit cost projections also consider the estimated cost impact of new technologies, service availability/mandates, or other factors that might influence the mix of procedures. Unit cost is based on our contractual changes with providers.

In addition, market-level healthcare affordability activities that are expected to impact forward-looking medical costs are recognized. Depending on the nature of individual initiatives, the impact may be recognized in one or more of the component cost items discussed above. Only incremental activities are recognized for this purpose in the expected trend impact for any particular period.

## **Section 7: Credibility Manual Rate Development**

## Source and Appropriateness of Data Used

• The combined experience of UnitedHealthcare Insurance Company, Optimum Choice Inc, and UnitedHealthcare of Mid Atlantic in District of Columbia was used for rate development.

## Adjustments Made to the Data

Adjustments similar to the ones described in Section 6 were applied to the experience of the credibility manual to project it to the projection period. In addition, the credibility manual was adjusted to reflect the average age, geography, plan design and morbidity of the adjusted experience period claims.

## **Inclusion of Capitation Payments**

Capitation payments are included in both the experience and projections.

## Section 8: Credibility of Experience

The experience for this legal entity contains 106,051 member months which does not exceed the 360,000 member months needed to be considered fully credible. As such the credibility of UnitedHealthcare Insurance Company is set to 0%, and the remaining uses the credibility manual described above.

Consideration was given to ASOP #25 when determining the credibility and appropriateness of the experience and the manual rate. The manual rate is sufficiently independent from the experience and can be blended with it for purposes of rate development.

## Section 9: Paid-to-Allowed Ratio

Paid-to-allowed ratios were developed for each plan using the proprietary UnitedHealthcare pricing model. This model uses nationwide UnitedHealthcare experience, which is fully credible. Claim data is projected to the pricing period based on national projections of utilization and unit costs. These projections are done at the service category level (inpatient, outpatient, etc.). Benefit design parameters such as deductibles, copays, and coinsurance rates are applied to the claim distributions of the matching service category. Cost sharing is applied, and the values of each service category are summed to determine an overall benefit value, or paid-to-allowed ratio. In order to preserve consistency, the same claim experience and projection assumptions are applied to all plan relativity calculations.

The average paid-to-allowed ratio is based on the paid-to-allowed ratios developed for each plan using the model discussed above and weighting them by the projected membership by plan. The member distribution is discussed under Section 21 (*Membership Projections*) of this memorandum.

## Section 10: Risk Adjustment and Reinsurance

Experience Period Risk Adjustment and Reinsurance Adjustments (PMPMs)

Risk Adjustments for the experience period are not known at this time.

Our 2017 risk adjustment transfer PMPM is estimated using data provided to UnitedHealthcare as a result of our participation in a multi-state study done by a large, independent actuarial consulting firm. Based on the results of that study, we expect that risk level of the membership insured by UnitedHealthcare Insurance Company to be lower than the market. This results in an approximate adjustment of \$2.45 PMPM.

Since this is a small group filing and the state of District of Columbia chose not to combine its individual and small group markets, reinsurance recoveries are not applicable to this rate filing. As such, no adjustments were made to the experience.

#### Projected Risk Adjustments Net of Risk Adjustment User Fees

UnitedHealthcare Insurance Company anticipates paying an average of \$2.76 PMPM for risk adjustment transfers in the state of District of Columbia for the 2019 plan year. We are assuming the risk level of our business relative to that of our competitors for the 2019 plan year will be similar to what it was in the 2017 plan year. Since risk adjustment transfer payments are a function of the market level premium, our 2019 risk adjustment transfer PMPM amount is calculated by adjusting our estimated 2017 risk adjustment transfer PMPM amount for the projected market level trend, changes in reinsurance fees and recoveries, and other adjustments based on the overall financial performance of the market. The HHS Notice of Benefit and Payment Parameters for 2019 specifies a risk adjustment user fee of \$0.15 PMPM.

The projected risk adjustment transfers net of risk adjustment user fees are therefore \$-2.91 PMPM.

#### Projected ACA Reinsurance Recoveries Net of Reinsurance Premium

The reinsurance program ended in 2016. As such, reinsurance premiums were not included in the 2019 rate development.

## Section 11: Non-Benefit Expenses and Profit

## Administrative Expense Load

The administrative expense load is a long-term estimate of administrative expenses, including selling expenses and general administrative expenses. This load does not vary by product or plan. These assumptions are based on the general ledger actual results (GAAP) for 2017 with known adjustments. Known adjustments include, but are not limited to, pay increases/raises for employees and administrative expenses as a result of Healthcare Reform and compliance requirements. The administrative expense allocation methodology used in pricing is appropriate because it is consistent with how UnitedHealthcare runs its business and how it allocates administrative costs for Statutory Filings and the Healthcare Reform Exhibits.

## **Profit and Risk Margin**

The profit and risk margin is shown in Worksheet 1, Section III of the URRT. This target does not vary by product or plan.

The profit and risk margin is derived from the difference between the target loss ratio and the administrative expenses, taxes and fees.

The profit and risk margin results in an anticipated MLR that is above the minimum requirements as described in the Projected Loss Ratio section.

## Taxes and Fees

Taxes and fees are expected to be 5.3% and include premium tax, exchange fees, PCORI fees, and federal income tax. The following is a breakdown of the taxes and fees.

Premium Taxes and Fees Allocation	Estimated % of Premium
Federal / State Income Tax on Profit & Risk Load	0.8%
Premium Tax	2.0%
ACA Taxes: Insurer Fee	1.4%
ACA Taxes: Reinsurance Fee	0.0%
ACA Taxes: PCORI Fee	0.0%
ACA Taxes: Risk Adjustment User Fee	0.0%
ACA Taxes: Exchange User Fee	1.0%
All Other Taxes & Fees	0.1%
Total	5.3%

<sup>\*</sup>Marketplace user fees are applied as and adjustment to the Index Rate at the market level. The value reflects the expected mix of Marketplace and non-marketplace enrollees.

## **Section 12: Projected Loss Ratio**

The projected loss ratio using the federally prescribed MLR methodology for calendar year 2019 is 83.3%. UnitedHealthcare Insurance Company agrees to comply with the rebate requirements of 45 CFR Part 158 should the actual market MLR fall below the 80.0% requirement.

## **Section 13: Single Risk Pool**

The single risk pool reflects all covered lives for every small group non-grandfathered product and plan combination for UnitedHealthcare Insurance Company in the state of District of Columbia. It is established in accordance with the requirements of 45 CFR §156.80(d).

## **Section 14: Index Rate**

The Index Rate for the experience period is approximately 98.52% of allowed claims due to benefits in excess of EHBs. The reported percentage amount is based on experience data. The index rate of the experience period has been reported accordingly, rounded to the nearest whole dollar value as required by the URRT. The Index Rate in the projection period represents 98.52% of allowed claims due to the benefits in excess of EHBs.

### Small Group Trend Adjustment

We are proposing premium rates that trend by quarter. The trend assumption only includes unit cost and utilization trend as this calculation is on an allowed basis.

	Q1	Q2	Q3	Q4	Average
CY 2019 Index Rate	\$ 467.89	\$ 467.89	\$ 467.89	\$ 467.89	\$ 467.89
Average Quarterly Trend	1.003	1.024	1.043	1.065	1.037
Quarterly Index Rate	\$ 469.43	\$ 479.22	\$ 487.78	\$ 498.11	\$ 485.29
Member Months	28,654	17,749	19,609	40,039	106,051

## **Section 15: Market Adjusted Index Rate**

The market adjusted index rate includes market-wide adjustments for the risk adjustment program and exchange user fees. Please refer to Section 10 (*Risk Adjustment*) and Section 11 (*Non-Benefit Expenses and Profit*) of this memorandum for a brief description of each of these items. Incurred values were grossed up by the average paid-to-allowed ratio to reflect an allowed basis.

Index Rate	Net Risk Adjustment (allowed basis)	Exchange Fee Adjustment (allowed basis)	Market Adjusted Index Rate
\$485.29	\$3.33	\$6.04	\$494.65

The figures above may not tally exactly due to rounding of the display.

## **Section 16: Plan Adjusted Index Rates**

The development of the projected index rate and all rating factors is in compliance with all applicable federal statutes and regulations (45 CFR 156.80 and 147.102)

## Actuarial Value and Cost Sharing Adjustment

UnitedHealthcare has a proprietary pricing model that was used in developing the actuarial value and cost sharing adjustment for each plan. The model calculates plan relativity factors for medical and pharmacy benefits. Also included under the actuarial value and cost sharing adjustment are adjustments for leveraging and the difference between the average plan relativity factor and the projected paid to allowed ratio.

UnitedHealthcare Insurance Company does not utilize Induced Demand factors in our rate development. Instead, our plan-specific pricing factors are based on an analysis of UnitedHealthcare Insurance Company's nationwide block of Small Group health insurance, which reflects over 10 million member months of experience. Our approach complies with the prohibition of rating for morbidity differences by normalizing out the cost differences attributable to morbidity as measured by HHS's risk adjustment mechanism.

Historical UnitedHealthcare experience was used to develop the actuarial value and cost sharing adjustment.

### Provider network, delivery system and utilization management adjustment

Any adjustments for these items are included in the plan relativity factors.

#### Benefits in Addition to EHBs

The Index Rate for the experience period is approximately 98.52% of allowed claims due to benefits in excess of EHBs. The reported percentage amount is based on experience data. The index rate of the experience period has been reported accordingly, rounded to the nearest whole dollar value as required by the URRT. The Index Rate in the projection period represents 98.52% of allowed claims due to the benefits in excess of EHBs.

#### **Distribution and Administrative Costs**

Distribution and administrative costs include premium tax, PCORI fees, SG&A, quality improvements, federal income tax, and after-tax income. These items were previously discussed in Section 11 (*Non-Benefit Expenses and Profit*) of this memorandum. Risk adjustment transfers and user fees and exchange fees are excluded because they are accounted for in the market adjusted index rate.

## Section 17: Calibration

Plan Adjusted Index Rates need to be calibrated to apply the allowable rating factors of age and geography in order to calculate the Consumer Adjusted Premium Rates. Calibration factors are applied uniformly to all plans.

#### **Age Calibration**

The calculated age curve calibration is 1.049, which equals the average age factor of the expected member distribution by age. This corresponds with an approximate age of 41 years. The age factors used in this calculation are the HHS-specified age curve.

## **Geographic Calibration**

The geographic factor calibration is 1, which equals the expected average area factor. A table of the geographic rating factors is below.

Rating Area	Area Factor
1	1.000

Geographic rating factors are reviewed periodically versus UnitedHealthcare claims data that reflects unit cost differences by county. Such a review was conducted as part of our January 1, 2019 rate development.

Our analysis did not indicate that there were credible, material differences indicated by the comparison of currently approved area factors and the UHC data reflecting unit cost differences.

Population morbidity by area was not considered when determining geographic area factors.

Calibrating the plan adjusted index rate to the age curve and geographic distribution results in the calibrated premium rate for each plan. The calibrated premium rate represents the preliminary premium rate charged to an individual before applying the consumer specific rating adjustments for age and area.

## **Tobacco Calibration**

Tobacco factors are not used in the rating of these products, and no calibration is needed.

## **Section 18: Consumer Adjusted Premium Rate Development**

The consumer adjusted premium rate is the final premium rate that is charged to an individual. It is developed by calibrating the plan adjusted index rate by the average age and geographic rating factors, and applying the consumer specific age and geographic rating factors. The calculation is provided below.

Plan Adjusted Index Rate

/ Age Calibration Factor

/ Geographic Calibration Factor

- \* Consumer Specific Age Rating Factor
- \* Consumer Specific Geographic Rating Factor
- \* Small Group Trend Adjustment
- =Consumer Adjusted Premium Rate

## **Small Group Trend Adjustment**

Since this is a small group filing that includes rates with scheduled trend increases by quarter, the Index Rate, Market Adjusted Index Rate and Plan Adjusted Index Rate reflect the member weighted average premium over the calendar year. As such, the Consumer Adjusted Premium Rate needs to include a trend adjustment specific to the quarter for which the rates are being calculated. The trend factors used to develop the consumer adjusted premium rates are shown below.

	Quarterly Trend	Average Trend	Trend Adjustment
	(a)	(b)	(a) / (b)
Q1	1.01	1.041	0.970
Q2	1.03	1.041	0.990
Q3	1.05	1.041	1.009
Q4	1.071	1.041	1.029

## Section 19: AV Metal Values

The AV calculator used to calculate the AV metal values is based on a prescribed methodology and, therefore, does not necessarily reflect a reasonable estimate of the portion of allowed costs covered by the associated plan. Please refer to Section 9 (*Paid-to-Allowed Ratio*) of this memorandum for further detail regarding our estimate of the portion of allowed costs covered by each plan.

Some plans within this portfolio have cost sharing features that differ between individual and family coverage (i.e., when two or more people are covered by the plan). For all plans, consistent with the Actuarial Value Calculator inputs, we have used only the cost sharing provisions applicable for individuals in the actuarial value calculation.

The AV calculator was used to determine the AV metal values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans. Some of our plan designs are not directly compatible with the AV calculator. The values were developed in accordance with generally accepted actuarial principles and methodologies. Additional details are provided below to describe the types of adjustments that were made for plan designs that are not directly compatible with the AV calculator.

#### Copays Paid in Conjunction with Coinsurance

Some of our plan designs include copays that are paid in conjunction with coinsurance in the coinsurance range. This benefit design is not directly compatible with the AV calculator, so the alternate methodology described in 45 CFR 156.135(b)(2) was used for the AV calculation. In order to modify the AV calculator input for a copay paid in conjunction with coinsurance, the following formula was used to estimate the insurer's cost share.

Effective Insurer Coinsurance Rate = (1 – Member Copay/Average Unit Cost) \* (1-Member Coinsurance Rate)

The benefit was then marked as "Subject to Deductible" and "Subject to Coinsurance" with a "Coinsurance, if different" equal to the effective insurer coinsurance rate as calculated above. The copay was entered in the "Copay if separate" column.

The average unit cost was calculated based on the claims data included within the AV calculator continuance tables for each metal level. For example, if the plan was expected to fall within a Silver Metal Tier, the average unit cost was calculated from the Silver continuance tables. All enrollees within a continuance table whose claims exceeded \$1,500 were included in the calculation of the average unit cost for each benefit type.

#### Benefits that Vary Based on Place of Service

For some types of services, our plan designs include different benefit levels based on the place of service (i.e. physician's office, free standing facility, or outpatient hospital facility). To incorporate this differentiation in benefits, the Tiered Network Option was selected within the AV calculator, and utilization was assigned to each tier based on historical experience of affiliated carriers.

#### **HRA Contributions**

Plan designs with HRA contributions of \$X apply to the member's final \$X of their deductible. To calculate a final AV, an adjustment was applied to the results of an AV run where the employer HRA contribution was \$0. The adjustment was equal to the difference in AV of runs where (1) the employer HRA contribution was equal to the deductible and (2) the employer contribution was equal to the deductible minus \$X.

#### **Physician Tiering**

Select plan designs include lower cost sharing when members utilize providers we designate as meeting cost and efficiency standards. The tiered network functionality of the AV calculator was utilized to account for the cost sharing differences. The utilization of providers was based on a UnitedHealthcare study of differences in cost sharing and their effectiveness at driving utilization patterns.

## Per Occurrence Copays

Select plan designs have per occurrence copays where a copay is paid before coinsurance is applied between the deductible and maximum out of pocket. These copays accumulate to the maximum out of pocket. To reflect this type of benefit an effective insurer coinsurance rate was calculated based on the average unit cost of the service and member coinsurance rate. The calculation is as follows:

Effective Insurer Coinsurance Rate = (1 – Member Copay/Average Unit Cost) \* (1-Member Coinsurance Rate)

Some of the copays only apply to portions of the benefit categories that the AV calculator defines. For example, the Inpatient Hospital Services includes both physician and facility charges. To the extent the plan design per occurrence copay only applies to a portion of the services, the tiered Network functionality was utilized. The mix of services within the AV calculator benefit categories was based on historical experience.

The average unit cost was calculated based on the claims data included within the AV calculator continuance tables for each metal level where available.

## **Section 20: AV Pricing Values**

The AV pricing values represent the cumulative effect of adjustments made by the issuer to move from the market adjusted index rate to the plan adjusted index rate. Each of the allowable modifiers to move from the market adjusted index rate to the plan adjusted index rate was previously discussed in Section 16 (*Plan Adjusted Index Rates*) of this memorandum.

## **Section 21: Membership Projections**

The 2019 plan year membership projection was developed utilizing the experience period plan level membership distribution along with sales and persistency targets. Member distribution by plan was then based on current enrollment, taking into consideration changes in the portfolio of plans to be offered in 2019. Strictly for purposes of the URRT, we have projected membership by plan.

## **Section 22: Terminated Products**

There are no products being terminated in this rate filing.

Some plans are being terminated as of the end of 2018. See the appendix for a list of terminated plans. The terminated plans, if any, are not being mapped to specific plans. Rather, at renewal, employers are given the option to select from multiple plans.

## Section 23: Plan Type

A plan type of EPO & POS has been selected, which describes the plans exactly.

## **Section 24: Warning Alerts**

There are no warning alerts on Worksheet 2 of the URRT.

## Section 25: Reliance

Due to responsibility allocation, I have relied upon other individuals within the UnitedHealthcare organization to provide certain assumptions. Although I have performed a limited review of the information and have not found it unreasonable or inconsistent, I have not reviewed it in enough detail to fully judge the reasonableness of the information due to the substantial amount of additional time required. I have therefore relied upon the expertise of those individuals who have developed the assumptions, and am providing the information required by Actuarial Standard of Practice 41, section 4.3. A list of reliances is included below.

## <u>UnitedHealthcare Finance Department</u>

- Projected SG&A Assumption
- Total Projected Membership

## <u>UnitedHealthcare National Pricing Team</u>

• Plan Relativity Modeling

## UnitedHealthcare Healthcare Economics Department

- Projected Trend
- Estimates of Incurred but not Paid Claims
  - ACO/Premium Designated Provider
- Cost Savings Estimates
- Plan Relativity Modeling

#### Section 26: Actuarial Certification

I, Ryan Morgan, FSA, MAAA, am a Director, Actuarial Services for UnitedHealthcare, and a member of the American Academy of Actuaries. I meet the Academy's qualification standards for rendering statements of actuarial opinion with respect to the filing of rates for health insurance products.

To the best of my knowledge and judgment, I certify that:

- The projected index rate is:
  - In compliance with state and federal statutes and regulations related to the development of the index rate and allowable rating factors (such as 45 CFR 156.80 and 147.102).
  - Developed in compliance with the applicable Actuarial Standards of Practice.
  - Reasonable in relation to the benefits provided and population anticipated to be covered.
  - Neither excessive, deficient, nor unfairly discriminatory.
- The index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CRF 156.80(d)(2) were used to generate plan level rates.
- The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.
- The geographic rating factors reflect only differences in the costs of delivery and do not include differences for population morbidity by geographic area.
- The AV calculator was used to determine the AV metal values shown in Worksheet 2 of the Part I Unified
  Rate Review Template for all plans. Some of our plan designs are not directly compatible with the AV
  calculator. The values were developed in accordance with generally accepted actuarial principles and
  methodologies. The unique plan design actuarial certification required by 45 CFR Part 156.135.
- The Part I Unified Rate Review Template does not demonstrate the process used by the issuer to
  develop their rates. Rather, it represents information required by federal regulation to be provided in
  support of the review of rate increases, for certification of qualified health plans for federally facilitated
  exchanges, and for certification that the index rate is developed in accordance with federal regulation
  and used consistently and only adjusted by the allowable modifiers.

Ryan Morgan	5/31/2018
Ryan Morgan, FSA, MAAA	Date
Director, Actuarial Services	



10701 West Research Drive, WI030-1000 Wauwatosa, WI 53226

Phone 414-443-4287

E-Mail: ryan\_morgan2@uhc.com

June 1, 2018

Efren Tanhehco, Actuary DC Department of Insurance Securities & Banking 810 First Street, NE Suite 701 Washington, DC 20002

Re: UnitedHealthcare Insurance Company

Small Group Rate Filing

Dear Mr. Tanhehco:

This rate filing presents proposed premium rates effective January 1, 2019 through December 31, 2019 for medical and Rx benefit plans to be sold by the UnitedHealthcare Insurance Company to small group employers. The benefit plans and rates are for non-grandfathered employers.

A. Company Name: UnitedHealthcare Insurance Company

B. NAIC Company Code: 79413

C. SERFF Tracking #: UHLC-131461282

D. Date Filing Submitted: 06/01/2018

E. Proposed Effective Date: 1/1/2019

F. Type of Product: Medical and prescription drug insurance, offered both in-network only and innetwork with out-of-network benefits.

G. Market: Small group, employers with 50 or fewer eligible employees.

H. Scope and Purpose of Filing: 2019 rates for small group plans meeting the requirements of the Patient Protection and Affordable Care Act (PPACA).

I. Initial Filing or Rate Change: Initial filing for 2019, rate change to previously filed and approved 2018 rates.

J. Rates apply to existing DC policyholders.

Cyan Morgan

K. Overall Premium Impact of Filing on DC Policyholders: An average 17.9% renewal rate increase.

L. Contact Information: Ryan Morgan, 414-443-4287; Email: ryan\_morgan2@uhc.com.

If you have any questions, please do not hesitate to reach out.

Sincerely,

Ryan Morgan, FSA, MAAA Director, Actuarial Services

Α	ВС	D	E	F	G	Н	l J	K	L	М	N O	Р	Q	R	S	Т	J V	Х	
	Unified Rate R	eview v4.3																	
					<b>6.</b> .														
	Company Legal HIOS Issuer ID:		UnitedHealtho	are Insurance Co		DC Small Group													
		of Rate Change(s):	-		Market:	Small Group													
	Lifective Date	or Nate Change(s).	1/1/2019																
	Market Level Calcu	ulations (Same for all Pl	lans)																
•	Section I: Experien	ice period data																	
	Experience Period:		1/1/2017	to	12/31/2017														
				Experience Period															
	D	MID Dahata) ia Farancia	Daniani	Aggregate Amount	PMPM \$441.63	% of Prem													
	Incurred Claims in	MLR Rebate) in Experie Experience Period	ence Perioa:	\$46,835,303 \$39,193,127	369.57	100.00% 83.68%													
	Allowed Claims:	Experience i criou		\$45,972,173		98.16%													
	Index Rate of Expe				\$427.00														
	Experience Period	Member Months		106,051															
	Section II: Allowed	Claims, PMPM basis																	
				Experience	e Period			ection Period:			12/31/2019	N	lid-point to Mi	d-point, Experie	nce to Projection:	24 r	months	_	
				on Actual Exper	iones Alloued		•	Experience to ion Period	Annualize Fact		Drainstions	before credibility	۸ مانانده سده سه		Credibility Manual				
			Utilization	Utilization per			Pop'l risk		raci	UIS	Utilization per		Aujustment	Utilization		_			
	Benefit Cate	gorv	Description	1,000	Average Cost/Service	PMPM	Morbidity		Cost	Util	1,000	Average Cost/Service	PMPM	per 1,000	Average Cost/Service	PMPM			
	Inpatient Ho		Days	165.77	\$6,168.63	\$85.21	1.005	0.983	1.039	1.035	178.46	\$6,545.96	\$97.35	180.65	\$6,265.18	\$94.32			
	Outpatient F	Hospital	Services	6,836.26	241.36	137.50	1.005	0.983	1.039	1.035	7,359.79	256.12	157.08	6843.71	261.36	149.06			
	Professional Other Medic	·al	Visits Services	6,369.95 500.00	221.21 84.46	117.43 3.52	1.005 1.005	0.983 0.983	1.039 1.039	1.035 1.035	6,857.77 538.29	234.74 89.63	134.15 4.02	6528.28 537.38	234.16 86.72	127.39 3.88			
	Capitation	.ai	Benefit Period	12,000.00	15.82	15.82	1.005	0.983	1.039	1.035	12,918.97	16.79	18.07	12897.16	16.63	17.87			
	Prescription	Drug	Prescriptions	7,176.06	123.77	74.01	1.005	0.983	1.039	1.035	7,725.61	131.34	84.56	7553.33	130.90	82.39			
	Total					\$433.49							\$495.24			\$474.91	After Credibility	Projected Period T	Fatala
	Section III: Project	ed Exnerience				Projected Allowed	Claims PMPM (	w/annlied cred	hibility if annl	icable)			0.00%			100.00%	\$474.91	\$50,36	
		<del></del>				,		wed Average F					0.007.				0.862		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
							,	curred Claims,		ein & Risk Ad	j't, PMPM						\$409.37	\$43,41	
							-	isk Adjustment									<u>-2.91</u>		8,608)
								CA reinsurance			overies, net of rein p	rem, PIVIPIVI					\$412.28 0.00	\$43,72	.2,834
						Projected Incurred	-	er (Temparance		ice of rem pre	,.						\$412.28	\$43,72	<u> </u>
						Administrative Exp	ense Load									13.70%	72.37	7,67	4,604
						Profit & Risk Load										3.03%	16.01	1,69	7,376
						Taxes & Fees			_							5.22%	27.57		4,192
						Single Risk Pool Gr Index Rate for Proj		/g. Rate, PMPN	И								\$528.23 \$485.29	\$56,01	9,005
						ilidex Nate IOI FIOJ		over Experience	e Period								19.61%		
							% Increase,										9.37%		
						Projected Membe	Months											10	6,051
	Information	Not Releasable to the I	Public Unless Author	ized by Law: This in	formation has n	ot been publically o	lisclosed and m	ay be privilege	d and confide	ntial. It is for	internal governmer	it use only and mu	st not be						
			l, distributed, or copi																

#### Product-Plan Data Collection

Company Legal Name: HIOS Issuer ID: Effective Date of Rate Change(s): UnitedHealthcare Insurance Company 41842 1/1/2019

State: DC Market: Small Group

Product	'M	Laurel	Caller	desiene

,																							
Section I: General Product and Plan Information																							
Product												DC00	L Plans										
Product ID:												41842	DC001										
Metal:		Not Applicable	Platinum	Platinum	Platinum	Gold	Silver	Silver	Silver	Platinum	Platinum	Gold	Gold	Silver	Silver	Silver							
AV Metal Value		0.000	0.888	0.878	0.914	0.819	0.812	0.812	0.807	0.797	0.804	0.788	0.763	0.711	0.710	0.717	0.895	0.880	0.796	0.799	0.720	0.707	0.718
AV Pricing Value	1	0.000	1.186	1.247	1.286	1.073	0.925	0.953	0.910	1.054	0.991	0.916	0.854	0.855	0.743	0.746	0.010	0.010	0.010	0.010	0.010	0.010	0.010
Plan Category	1	Terminated	Renewing	New	New	New	Renewing	Renewing	New	Terminated													
Plan Type:		POS																					
																						1	
Plan Name		Terminated																				1	
		Products	BH-FW	BH-F3	BH-ES	BH-EY	BH-FX	BH-FQ	BH-FM	BH-E4	BH-E6	BH-FF	BH-FS	BH-FU	BH-FT	BH-FI	AT-YT	AT-ZS	AT-ZJ	AT-Y1	AT-Y3	AT-YS	AT-Y9
Plan ID (Standard Component ID):		41842DC0010000	41842DC0010066	41842DC0010068	41842DC0010074	41842DC0010006	41842DC0010032	41842DC0010042	41842DC0010054	41842DC0010078	41842DC0010081	41842DC0010082	41842DC0010084	41842DC0010043	41842DC0010080	41842DC0010083	41842DC0010001	41842DC0010031	41842DC0010069	41842DC0010075	41842DC0010076	41842DC0010077	41842DC0010079
Exchange Plan?		No	Yes	3a,	Yes	Yes	Yes	Yes	Yes	Yes													
Historical Rate Increase - Calendar Year - 2												0.0	10%										
Historical Rate Increase - Calendar Year - 1												0.0	10%										
Historical Rate Increase - Calendar Year 0												-0.	76%										
Effective Date of Proposed Rates		1/1/2019	1/1/2019	1/1/2019	1/1/2019	1/1/2019	1/1/2019	1/1/2019	1/1/2019	1/1/2019	1/1/2019	1/1/2019	1/1/2019	1/1/2019	1/1/2019	1/1/2019	1/1/2019	1/1/2019	1/1/2019	1/1/2019	1/1/2019	1/1/2019	1/1/2019
Rate Change % (over prior filing)		0.00%	19.60%	20.70%	11.80%	12.00%	6.60%	11.90%	5.80%	20,20%	0.00%	0.00%	0.00%	13.40%	5.40%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Cum'tive Rate Change % (over 12 mos prior)		0.00%	26.40%	27.50%	18.20%	18.40%	12.60%	18.30%	11.80%	27.00%	0.00%	0.00%	0.00%	19.80%	11.40%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Proi'd Per Rate Change % (over Exper. Period)		#DIV/0!	20.46%	20.41%	22.21%	26.69%	11.52%	8.10%	11.17%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	26.80%	#DIV/0!	#DIV/0!	-100.00%	-100.00%	-100.00%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Product Rate Increase %												19.	75%										

#### Section II: Components of Premium Increase (PMPM Dollar Amount above Current Average Rate PMPM)

Plan ID (Standard Component ID):	Total	41842DC0010000	41842DC0010066	41842DC0010068 4	\$1842DC0010074	41842DC0010006	41842DC0010032	41842DC0010042 4	1842DC0010054	41842DC0010078	41842DC0010081	41842DC0010082	41842DC0010084 4:	1842DC0010043	41842DC0010080	41842DC0010083	41842DC0010001	41842DC0010031	11842DC0010069	1842DC0010075	41842DC0010076 418	42DC0010077 4184	42DC0010079
Inpatient	\$1.13	\$0.00	\$0.79	\$1.67	\$9.98	\$0.09	\$0.23	\$0.01	\$0.19	\$13.03	\$0.00	\$0.00	\$0.00	\$7.43	\$2.80	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Outpatient	\$1.82	\$0.00	\$1.27	\$2.69	\$16.10	\$0.14	\$0.37	\$0.01	\$0.31	\$21.02	\$0.00	\$0.00	\$0.00	\$11.99	\$4.52	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Professional	\$1.55	\$0.00	\$1.09	\$2.30	\$13.75	\$0.12	\$0.32	\$0.01	\$0.27	\$17.95	\$0.00	\$0.00	\$0.00	\$10.24	\$3.86	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Prescription Drug	\$0.98	\$0.00	\$0.69	\$1.45	\$8.67	\$0.08	\$0.20	\$0.01	\$0.17	\$11.31	\$0.00	\$0.00	\$0.00	\$6.45	\$2.43	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Other	\$0.05	\$0.00	\$0.03	\$0.07	\$0.41	\$0.00	\$0.01	\$0.00	\$0.01	\$0.54	\$0.00	\$0.00	\$0.00	\$0.31	\$0.12	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Capitation	\$0.21	\$0.00	\$0.15	\$0.31	\$1.85	\$0.02	\$0.04	\$0.00	\$0.04	\$2.42	\$0.00	\$0.00	\$0.00	\$1.38	\$0.52	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Administration	\$1.01	\$0.00	\$0.71	\$1.49	\$8.91	\$0.08	\$0.21	\$0.01	\$0.17	\$11.64	\$0.00	\$0.00	\$0.00	\$6.64	\$2.50	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Taxes & Fees	\$0.39	\$0.00	\$0.27	\$0.57	\$3.42	\$0.03	\$0.08	\$0.00	\$0.07	\$4.46	\$0.00	\$0.00	\$0.00	\$2.54	\$0.96	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Risk & Profit Charge	\$0.22	\$0.00	\$0.16	\$0.33	\$1.97	\$0.02	\$0.05	\$0.00	\$0.04	\$2.57	\$0.00	\$0.00	\$0.00	\$1.47	\$0.55	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Total Rate Increase	\$7.36	\$0.00	\$5.15	\$10.86	\$65.06	\$0.56	\$1.50	\$0.05	\$1.25	\$84.93	\$0.00	\$0.00	\$0.00	\$48.46	\$18.25	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Member Cost Share Increase	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
<u> </u>																							
Average Current Rate PMPM	\$118.22	\$0.00	\$26.27	\$52.47	\$551.40	\$4.70	\$22.70	\$0.45	\$21.64	\$420.46	\$0.00	\$0.00	\$0.00	\$361.61	\$338.03	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Projected Member Months	106,051	0	17,781	25,858	13,807	10,939	11,513	6,701	2,702	306	306	306	306	2,586	135	135	0	0	0	0	0	0	0

#### Section III: Experience Period Information

Plan ID (Standard Component ID):	Total	41842DC0010000	41842DC0010066	41842DC0010068 4	1842DC0010074 4	1842DC0010006	41842DC0010032 4	1842DC0010042 4	1842DC0010054	41842DC0010078	41842DC0010081	41842DC0010082	41842DC0010084	41842DC0010043	41842DC0010080	41842DC0010083	41842DC0010001	41842DC0010031	41842DC0010069	1842DC0010075 4	1842DC0010076 41	842DC0010077 4	41842DC0010079
Plan Adjusted Index Rate	\$344.63	\$0.00	\$487.13	\$512.33	\$520.58	\$418.92	\$410.36	\$436.24	\$404.82	\$0.00	\$0.00	\$0.00	\$0.00	\$333.54	\$0.00	\$0.00	\$477.96	\$503.23	\$410.95	\$0.00	\$0.00	\$0.00	\$0.00
Member Months	106,051	25,757	9,621	14,314	7,312	9,990	10,529	6,008	2,251	0	0	0	0	1,288	0	0	4,328	3,594	2,278	0	0	0	0
E Total Premium (TP)	\$46,835,303	\$8,351,117	\$5,195,016	\$7,845,829	\$3,987,230	\$4,321,356	\$4,469,247	\$2,625,288	\$1,023,245	\$0	\$0	\$0	\$0	\$410,827	\$0	\$0	\$2,160,676	\$1,993,798	\$955,005	\$0	\$0	\$0	\$0
op .																							
EHB Percent of TP, [see instructions]	99.13%	100.00%	98.89%	98.25%	98.89%	98.64%	99.23%	98.66%	99.16%	100.00%	100.00%	100.00%	100.00%	97.79%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
state mandated benefits portion of TP that are other																							
than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other benefits portion of TP	0.87%	0.00%	1.11%	1.75%	1.11%	1.36%	0.77%	1.34%	0.84%	0.00%	0.00%	0.00%	0.00%	2.21%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total Allowed Claims (TAC)	\$45,972,173	\$11,339,647	\$5,314,729	\$4,795,592	\$3,879,349	\$4,258,553	\$5,042,772	\$2,527,886	\$998,494	\$0	\$0	\$0	\$0	\$358,137	\$0	\$0	\$2,055,816	\$1,696,686	\$940,204	\$0	\$0	\$0	\$0
EHB Percent of TAC, [see instructions]	99.24%	100.00%	98.89%	98.25%	98.89%	98.64%	99.23%	98.66%	99.16%	100.00%	100.00%	100.00%	100.00%	97.79%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
state mandated benefits portion of TAC that are																							
other than EHB	0.00%		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other benefits portion of TAC	0.76%	0.00%	1.11%	1.75%	1.11%	1.36%	0.77%	1.34%	0.84%	0.00%	0.00%	0.00%	0.00%	2.21%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Allowed Claims which are not the issuer's obligation:	\$6,779,046	\$1,523,866	\$474,014	\$523,739	\$318,295	\$968,771	\$953,295	\$435,164	\$188,223	\$0	so	\$0	\$0	\$154,719	\$0	so	\$259,144	\$140,892	\$205,680	\$0	\$0	\$0	\$0
Portion of above payable by HHS's funds																							
on behalf of insured person, in dollars	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Portion of above payable by HHS on																							
behalf of insured person, as %	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	0.00%	#DIV/0!	#DIV/0!	0.00%	0.00%	0.00%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/01
Total Incurred claims, payable with issuer funds	\$39,193,127	\$9,815,781	\$4,840,715	\$4,271,853	\$3,561,054	\$3,289,782	\$4,089,477	\$2,092,722	\$810,272	\$0	\$0	50	\$0	\$203,418	\$0	\$0	\$1,796,672	\$1,555,794	\$734,524	\$0	\$0	\$0	
Net Amt of Rein	\$0.00	\$0.00	60.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	so oo	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	****
Risk Adjustment Transfer Amount	-\$259.501.38	\$0.00	-\$35,030,33	-\$52,904,93	-\$26.886.15	-\$29 139 19	-\$30.136.43	-\$17,702,49	-\$6,899.81	\$0.00		\$0.00	\$0.00		\$0.00		-\$14 569 58	-\$13 444 31	-\$6,439,66	\$0.00	\$0.00	\$0.00	\$0.00
KISK AUGUSTIIERT TRAISIER ARROURT	-3239,301.30	30.00	-353,030.55	*332,304.33	*\$20,880.13	-329,139.19	*\$30,130.43	-317,702.45	-50,075.01	30.00	30.00	30.00	\$0.00	-32,770.23	30.00	30.00	*\$14,305.30	*313,444.31	*30,435.00	30.00	30.00	30.00	30.00
Incurred Claims PMPM	\$369.57	\$381.09	\$503.14	\$298.44	\$487.01	\$329.31	\$388.40	\$348.32	\$359.96	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	\$157.93	#DIV/0!	#DIV/0!	\$415.13	\$432.89	\$322.44	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Allowed Claims PMPM	\$433.49	\$440.25	\$552.41	\$335.03	\$530.55	\$426.28	\$478.94	\$420.75	\$443.58	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	\$278.06	#DIV/0!	#DIV/0!	\$475.00	\$472.09	\$412.73	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
EHB portion of Allowed Claims, PMPM	\$430.21	\$440.25	\$546.27	\$329.18	\$524.64	\$420.50	\$475.27	\$415.12	\$439.84	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	\$271.91	#DIV/0!	#DIV/0!	\$475.00	\$472.09	\$412.73	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Section IV: Projected (12 months following effective date	1																						
Plan ID (Standard Component ID):	Total	41842DC0010000	41842DC0010066	41842DC0010068	41842DC0010074	41842DC0010006	41842DC0010032	41842DC0010042	41842DC0010054	41842DC0010078	41842DC0010081	41842DC0010082 4	1842DC0010084	1842DC0010043	1842DC0010080 4	1842DC0010083 4	1842DC0010001	41842DC0010031	41842DC0010069	41842DC0010075	41842DC0010076	41842DC0010077	41842DC0010079
e Plan Adjusted Index Rate	\$549.41	\$0.00	\$586.81	\$616.89	\$636.21	\$530.74	\$457.63	\$471.57	\$450.05	\$521.35	\$490.29	\$452.86	\$422.32	\$422.93	\$367.62	\$369.13	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
을 Member Months	106,051		17,781	25,858	13,807	10,939	11,513	6,701	2,702	306	306	306	306	2,586	135	135	-					-	-
Total Premium (TP)	\$58,265,708	\$0	\$10,434,096	\$15,951,563	\$8,784,169	\$5,805,812	\$5,268,690	\$3,159,995	\$1,216,043	\$159,533	\$150,027	\$138,574	\$129,231	\$1,093,693	\$49,629	\$49,833	\$0	\$0	\$0	\$0	\$0	\$0	\$0
EHB Percent of TP, [see instructions]	98.52%	100.00%	98.52%	98.52%	98.52%	98.52%	98.52%	98.52%	98.52%	98.52%	98.52%	98.52%	98.52%	98.52%	98.52%	98.52%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
state mandated benefits portion of TP that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other benefits portion of TP	1.48%	0.00%	1.48%	1.48%	1.48%	1.48%	1.48%	1.48%	1.48%	1.48%	1.48%	1.48%	1.48%	1.48%	1.48%	1.48%	0.00%	0.00%		0.00%	0.00%	0.00%	0.00%
Total Allowed Claims (TAC)	\$50,364,530	\$0	\$8,721,170	\$12,682,752	\$6,772,015	\$5,023,615	\$5,287,218	\$3,077,360	\$1,240,864	\$140,527	\$140,527	\$140,527	\$140,527	\$1,109,958	\$57,944	\$57,944	\$0	\$0	\$0	\$0	\$0	\$0	\$0
EHB Percent of TAC, [see instructions]	98.52%	100.00%	98.52%	98.52%	98.52%	98.52%	98.52%	98.52%	98.52%	98.52%	98.52%	98.52%	98.52%	98.52%	98.52%	98.52%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other benefits portion of TAC	1.48%	0.00%	1.48%	1.48%	1.48%	1.48%	1.48%	1.48%	1.48%	1.48%	1.48%	1.48%	1.48%	1.48%	1.48%	1.48%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Allowed Claims which are not the issuer's obligation	\$6,641,697	\$0	\$891,380	\$712,632	\$180,337	\$666,909	\$1,333,570	\$706,086	\$328,340	\$20,813	\$27,946	\$36,541	\$43,552	\$289,246	\$20,703	\$20,549	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Portion of above payable by HHS's funds on behalf of insured person, in dollars	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Portion of above payable by HHS on behalf of insured person, as %	0.00%	#DIV/01	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	#DIV/0!	#DIV/01	#DIV/0!	#DIV/0!	#DIV/01	#DIV/0!	#DIV/01
Total Incurred claims, payable with issuer funds	\$43,722,834	\$0	\$7,829,789	\$11,970,120	\$6,591,678	\$4,356,706	\$3,953,647	\$2,371,274	\$912,524	\$119,714	\$112,581	\$103,987	\$96,975	\$820,712	\$37,241	\$37,395	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Net Amt of Rein	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Risk Adjustment Transfer Amount	-\$292,701	\$0	-\$49,076	-\$71,368	-\$38,107	-\$30,192	-\$31,776	-\$18,495	-\$7,458	-\$845	-\$845	-\$845	-\$845	-\$7,137	-\$373	-\$373	\$0	\$0	\$0	\$0	\$0	\$0	\$0

									DC004 Plans									
Platinum 0.888	Platinum 0.878	Gold 0.812	Gold 0.797	Gold 0.804	Gold 0.788	Gold 0.763	Gold 0.807	Silver 0.711	41842DC004 Silver 0.717	Silver 0.710	Bronze 0.613	Gold 0.796	Silver 0.701	Gold 0.790	Gold 0.799	Silver 0.720	Silver 0.707	Silver 0.718
1.168 Renewing EPO	1.229 Renewing EPO	0.938 Renewing EPO	1.044 Renewing EPO	0.972 New EPO	0.900 New EPO	0.839 New EPO	0.894 Renewing EPO	0.838 Renewing EPO	0.734 New EPO	0.730 Renewing EPO	0.626 Renewing EPO	0.010 Terminated EPO	0.010 Terminated EPO	0.010 Terminated EPO	0.010 Terminated EPO	0.010 Terminated EPO	0.010 Terminated EPO	0.010 Terminated EPO
RH-F2	RH-FS	RH-FR	RH-F7	RH-F7	RH-FF	RH-FV	RH-FN	RH-F7	RH-FH	RH-FY	RH-F3	ΔТ-7К	ΔT-YII	ΔT-YV	ΔΤ-Υ7	ΔΤ-Υ2	ΔΤ-ΥΔ	ΔΤ-٧8
41842DC0040059 Yes																		
								'	0.00%									
1/1/2019	1/1/2019	1/1/2019	1/1/2019	1/1/2019	1/1/2019	1/1/2019	1/1/2019	1/1/2019	-1.65% 1/1/2019	1/1/2019	1/1/2019	1/1/2019	1/1/2019	1/1/2019	1/1/2019	1/1/2019	1/1/2019	1/1/2019
19.70% 26.50%	20.90% 27.70%	12.10% 18.50%	20.30% 27.10%	0.00%	0.00%	0.00%	5.80% 11.90%		0.00%	5.50% 11.50%	13.20% 19.70%	0.00%	0.00%	0.00%		0.00%	0.00%	0.00%
#DIV/01	#DIV/0!	8.74%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	11.78%	28.28%	#DIV/0! 24.60%	6.55%	#DIV/0!	-100.00%	-100.00%	-100.00%	#DIV/0!	#DIV/01	#DIV/0!	#DIV/0!
41842DC0040059	41842DC0040060	41842DC0040045	41842DC0040057	41842DC0040061	41842DC0040062	41842DC0040064	41842DC0040091	41842DC0040046	11842DC0040063	41842DC0040101	41842DC0040008	41842DC0040047	41842DC0040052	41842DC0040053	41842DC0040054	41842DC0040055	41842DC0040056	41842DC0040058
\$14.14 \$22.81	\$15.63 \$25.21	\$0.15 \$0.24	\$12.96 \$20.90	\$0.00 \$0.00	\$0.00 \$0.00	\$0.00 \$0.00	\$0.56 \$0.90	\$0.25 \$0.40	\$0.00 \$0.00	\$0.72 \$1.17	\$5.37 \$8.67	\$0.00 \$0.00	\$0.00 \$0.00	\$0.00 \$0.00	\$0.00 \$0.00	\$0.00 \$0.00	\$0.00 \$0.00	\$0.00 \$0.00
\$19.48 \$12.28	\$21.53 \$13.57	\$0.21 \$0.13	\$17.85 \$11.25	\$0.00 \$0.00	\$0.00 \$0.00	\$0.00 \$0.00	\$0.77 \$0.48	\$0.34 \$0.21	\$0.00 \$0.00	\$1.00 \$0.63	\$7.40 \$4.66	\$0.00 \$0.00	\$0.00 \$0.00	\$0.00 \$0.00		\$0.00 \$0.00	\$0.00 \$0.00	\$0.00 \$0.00
\$0.58 \$2.62	\$0.65 \$2.90	\$0.01 \$0.03	\$0.54 \$2.41	\$0.00 \$0.00	\$0.00 \$0.00	\$0.00 \$0.00	\$0.02 \$0.10	\$0.01 \$0.05	\$0.00 \$0.00	\$0.03 \$0.13	\$0.22 \$1.00	\$0.00 \$0.00	\$0.00 \$0.00	\$0.00 \$0.00	\$0.00 \$0.00	\$0.00 \$0.00	\$0.00 \$0.00	\$0.00 \$0.00
\$12.63 \$4.84	\$13.96 \$5.35	\$0.14 \$0.05	\$11.57 \$4.43	\$0.00 \$0.00	\$0.00 \$0.00	\$0.00 \$0.00	\$0.50 \$0.19	\$0.22 \$0.08	\$0.00 \$0.00	\$0.65 \$0.25	\$4.80 \$1.84	\$0.00 \$0.00	\$0.00 \$0.00	\$0.00 \$0.00		\$0.00 \$0.00	\$0.00 \$0.00	\$0.00 \$0.00
\$2.79 \$92.19	\$3.09 \$101.88	\$0.03 \$0.99	\$2.56 \$84.47	\$0.00 \$0.00	\$0.00 \$0.00	\$0.00 \$0.00	\$0.11 \$3.62		\$0.00 \$0.00	\$0.14 \$4.72	\$1.06 \$35.02	\$0.00 \$0.00	\$0.00 \$0.00	\$0.00 \$0.00	\$0.00	\$0.00 \$0.00	\$0.00 \$0.00	\$0.00 \$0.00
\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
\$467.96 1,223	\$487.46 1.223	\$8.16 3.031	\$416.12 306	\$0.00	\$0.00	\$0.00	\$62.44 2.030	\$12.06 2.656	\$0.00	\$85.85	\$265.28 218	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	-,	5,555					2,200	-,,,,,										
41842DC0040059 \$0.00	41842DC0040060 \$0.00	41842DC0040045 \$426.48	41842DC0040057 \$0.00	41842DC0040061 \$0.00	41842DC0040062 \$0.00	41842DC0040064 \$0.00	41842DC0040091 \$395.51		\$1842DC0040063	41842DC0040101 \$338.76	41842DC0040008 \$0.00	41842DC0040047 \$399.29	41842DC0040052 \$337.62	41842DC0040053 \$390.75		41842DC0040055 \$0.00	41842DC0040056 \$0.00	41842DC0040058 \$0.00
0	0	2,560	0	0	0	0	1,620	1,325	0	418	0	2,621	3	234	0	0	0	0
\$0	\$0	\$1,113,424	\$0	\$0	\$0	\$0	\$671,137	\$413,259	\$0	\$133,455	\$0	\$1,084,815	\$986	\$79,591		\$0	\$0	\$0
100.00%	100.00%	99.50%	100.00%	100.00%	100.00%	100.00%	98.98%	97.33%	100.00%	99.01%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
0.00%	0.00% \$0	0.50% \$1,063,946	0.00% \$0	0.00%	0.00%	0.00% \$0	1.02% \$319,965	2.67% \$228,609	0.00%	0.99% \$75,694	0.00% \$0	0.00% \$1,000,205	0.00% \$47	0.00% \$75,842	0.00% \$0	0.00% \$0	0.00%	0.00%
100.00%	100.00%	99.50%	100.00%	100.00%	100.00%	100.00%	98.98%	97.33%	100.00%	99.01%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
0.00%	0.00%	0.50%	0.00%	0.00%	0.00%	0.00%	1.02%	2.67%	0.00%	0.99%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
\$0	\$0	\$150,474	\$0	\$0	\$0	\$0	\$98,782	\$114,092	\$0	\$11,670	\$0	\$224,945	\$0	\$33,282	\$0	\$0	\$0	\$0
\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
#DIV/0! \$0	#DIV/0! \$0	0.00% \$913,472	#DIV/0! \$0	#DIV/0! \$0	#DIV/01 \$0	#DIV/0! \$0	0.00% \$221,183	0.00% \$114,516	#DIV/0! \$0	0.00% \$64,024	#DIV/01 \$0	0.00% \$775,260	#DIV/0! \$47	0.00% \$42,560	#DIV/0! \$0	#DIV/0! \$0	#DIV/01 \$0	#DIV/0! \$0
\$0.00 \$0.00	\$0.00 \$0.00	\$0.00 -\$7,507.89	\$0.00 \$0.00	\$0.00 \$0.00	\$0.00 \$0.00	\$0.00 \$0.00	\$0.00 -\$4,525.52	\$0.00 -\$2,786.63	\$0.00	\$0.00	\$0.00 \$0.00	\$0.00	\$0.00 -\$6.65	\$0.00		\$0.00 \$0.00	\$0.00 \$0.00	\$0.00 \$0.00
#DIV/0!	#DIV/0!	\$356.82	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	\$136.53	\$86.43	#DIV/0!	\$153.17	#DIV/0!	\$295.79	\$15.82	\$181.88	#DIV/01	#DIV/0!	#DIV/0!	#DIV/0!
#DIV/0! #DIV/0!	#DIV/0! #DIV/0!	\$415.60 \$413.53	#DIV/0!	#DIV/0! #DIV/0!	#DIV/0! #DIV/0!	#DIV/0! #DIV/0!	\$197.51 \$195.50	\$172.53	#DIV/0!	\$181.09 \$179.30	#DIV/0!	\$381.61 \$381.61	\$15.82 \$15.82	\$324.11	#DIV/0!	#DIV/0!	#DIV/0! #DIV/0!	#DIV/0! #DIV/0!
	,					,	*******	<u></u>		¥2	,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, , , , , , , , , , , , , , , , , , ,	,,,,,,,			,	,
41842DC0040059	41842DC0040060	41842DC0040045	41842DC0040057	41842DC0040061	41842DC0040062	41842DC0040064	41842DC0040091	41842DC0040046	11842DC0040063		41842DC0040008							41842DC0040058
\$577.95 1,223	\$607.72 1,223	\$463.77 3,031	\$516.27 306	\$480.81 306	\$445.28 306	\$415.20 306	\$442.10 2,030	\$414.52 2,656	\$362.92 135	\$360.95 930	\$309.88 218	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
\$706,829	\$743,245	\$1,405,677	\$157,980	\$147,129	\$136,256	\$127,051	\$897,458	\$1,100,961	\$48,994	\$335,685	\$67,555	\$0	\$0	\$0		\$0	\$0	\$0
98.52%	98.52%	98.52%	98.52%	98.52%	98.52%	98.52%	98.52%	98.52%	98.52%	98.52%	98.52%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
1.48% \$599,853	1.48% \$599,853	1.48% \$1,391,953	1.48% \$140,527	1.48% \$140,527	1.48% \$140,527	1.48% \$140,527	1.48% \$932,255	1.48% \$1,140,003	1.48% \$57,944	1.48% \$399,173	1.48% \$88,440	0.00%	0.00% 0.00% \$0	0.00%	0.00%	0.00%	0.00%	0.00%
98.52%	98.52%	98.52%	98.52%	98.52%	98.52%	98.52%	98.52%	98.52%	98.52%	98.52%	98.52%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
1.48% \$69,446	1.48% \$42,119	1.48% \$337,127	1.48% \$21,979	1.48% \$30,121	\$38,280	1.48% \$45,187	1.48% \$258,799	1.48%	1.48% \$21,179	1.48% \$147,273	1.48%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	#DIV/01	#DIV/0!	#DIV/01	#DIV/0!	#DIV/0!	#DIV/01	#DIV/0!
\$530,407	\$557,734	\$1,054,826	\$118,548	\$110,406	\$102,247	\$95,340	\$673,456	\$826,166	\$36,766	\$251,899	\$50,694	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$0 -\$3,375	\$0 -\$3,375	\$0 -\$8,366	\$0 -\$845	\$0 -\$845	\$0 -\$845	\$0 -\$845	\$0 -\$5,603	\$0 -\$7,331	\$0 -\$373	\$0 -\$2 567	\$0 -\$602	\$0 \$0	\$0 \$0	\$0 \$0	\$0 \$0	\$0 \$0	\$0 \$0	\$0
-\$3,3/5		***************************************	-3045	*3045	*3045	-3045	-33,003	*37,331	-33/3	-32,367	*3002	\$0	50	- 50	\$0	\$0	\$0	30

## Rate Filing Justification Part II (Plain Language Summary)

Pursuant to 45 CFR 154.215, health insurance issuers are required to file Rate Filing Justifications. Part II of the Rate Filing Justification for rate increases and new submissions must contain a written description that includes a simple and brief narrative describing the data and assumptions that were used to develop the proposed rates. The Part II template below must be filled out and uploaded as an Adobe PDF file under the Consumer Disclosure Form section of the Supporting Documentation tab.

Name of Company	UnitedHealthcar	e Insurance Company
SERFF tracking number	UHLC-1314612	32
Submission Date	June 1, 2018	
Product Name	Medical and Pre	scription Drug Insurance
Market Type	Individual	Small Group
Rate Filing Type	Rate Increase	New Filing
Scope and Range of the The 17.9% increase is r		

This filing will impact:

# of policyholder's 1218 # of covered lives 9,777

Primarily because of significant deterioration in our 2017 experience and trend.

The average, minimum and maximum rate changes increases are:

- Average Rate Change: The average premium change, by percentage, across all policy holders if the filing is approved 17.9 %
- Minimum Rate Change: The smallest premium increase (or largest decrease), by percentage, that any one policy holder would experience if the filing is approved 11.0%
- Maximum Rate Change: The largest premium increase, by percentage, that any one policy holder would experience if the filing is approved 30.7%

Individuals within the group may vary from the aggregate of the above increase components as a result of:

The group's rate is based on the benefit plan selected and the attained ages of the members at the beginning of the policy period.

### **Financial Experience of Product**

The overall financial experience of the product includes:

Some membership growth, but a significant deterioration in the loss ratio from 69.5% in last year's filing to 81.7%.

The rate increase will affect the projected financial experience of the product by:

The projected loss ratio using the Federal prescribed MLR methodology is 83.3%

# **Components of Increase**

The request is made up of the following components:

Trend Increases – 8.1 % of the 17.9 % total filed increase

1. Medical Utilization Changes –Defined as the increase in total plan claim costs not attributable to changes in the unit cost of underlying services, or renegotiation of provider contracts. Examples include changes in the mix of services utilized, or an increase/decrease in the frequency of service utilization.

This component is 4.2 % of the 17.9 % total filed increase.

2. Medical Price Changes – Defined as the increase in total plan claim costs attributable to changes in the unit cost of underlying services, or renegotiation of provider contracts.

This component is 3.9 % of the 17.9 % total filed increase.

Other Increases – 9.8 % of the 17.9 % total filed increase

1. Medical Benefit Changes Required by Law – Defined as any new mandated plan benefit changes, as mandated by either State or Federal Regulation.

This component is % of the % total filed increase.

2. Medical Benefit Changes Not Required by Law – Defined as changes in plan benefit design made by the company, which are not required by either State or Federal Regulation.

This component is % of the % total filed increase.

3. Changes to Administration Costs – Defined as increases in the costs of providing insurance coverage. Examples include claims payment expenses, distribution costs, taxes, and general business expenses such as rent, salaries, and overhead.

This component is 0.4 % of the 17.9% total filed increase.

4. Changes to Profit Margin – Defined as increases to company surplus or changes as an additional margin to cover the risk of the company.

This component is 1.7 % of the 17.9 % total filed increase.

5. Other – Defined as:

Deterioration in experience (net of projected risk adjustment improvement)

This component is 7.7 % of the 17.9 % total filed increase.

# RATE FILING REQUIREMENTS INDIVIDUAL AND SMALL GROUP PLANS SOLD ON DC HEALTH LINK CHECK-LIST

INSTRUCTIONS: Include all required elements in the table below with the filed rates. The data elements listed in the Actuarial Memorandum should be consistent with the cover letter, if applicable.

Number	Data Element	Requirement Description	Individual and Small Group	all Group
			Has the Data Element Been Included?	Location of the Data Element
	Purpose of	State the purpose of the filing. Identify the applicable law.		
	Filing	List the proposed changes to the base rates and rating factors, and provide a general summary.	Yes	Actuarial Memo
2	Form Numbers	Form numbers should be listed in the actuarial memorandum.	Yes	Actuarial Memo
3	SOIH	The HIOS product ID should be listed in the actuarial	Yac	Actuarial Memo
	Product ID	memorandum.	G	
4	Effective Date	The requested effective date of the rate change. For filings effective 1/1/2017 and later, follow filing	Yes	Actuarial Memo
		due date requirements.		
5	Market	Indicate whether the products are sold in the individual or small employer group market.	Yes	Actuarial Memo
6	Status of	Indicate whether the forms are open to new sales, closed, or a	<b>.</b>	
	Forms	mixture of both, and whether the forms are grandfathered, non-grandfathered, or a mixture of both.	Yes	Actuarial Memo
7	Benefits/Metal level(s)	Include a basic description of the benefits of the forms referenced in the filing and the metal level of each plan design.	Yes	Actuarial Memo

Number	Data Element	Requirement Description	Individual and Small Group	ll Group
			Has the Data Element Been Included?	Location of the Data Element
7.1	AV Value	Provide the actuarial value of each plan design using the AV calculator developed and made available by HHS.	Yes	Exhibit 1
8	Average Rate	The weighted average rate increase being requested,		
	Increase Requested	be based on premium volume. In the small group market,	Yes	Actuarial Memo
		please also provide weighted average rate increase		
		requested for 2016Q1 over 2015Q1; etc.		
9	Maximum Rate	The maximum rate increase that could be applied to a		
	Increase	policyholder based on changes to the base rate and rating	<. }	Actuarial Memo
	Requested	factors, incremental and year-over-year renewal. (Does not	res	Condition Monto
		include changes in the demographics of the covered members.)		
10	Minimum Rate	The minimum rate increase that could be applied to a		
	Increase	policyholder based on changes to the base rate and rating	Yes	Actuarial Memo
	Requested	factors, incremental and year-over-year renewal. (Does not include changes in the demographics of the covered members.)		
*	Absoluta	The abcolute maximum year over year renewal rate increase		
	Maximum	that could be applied to a policyholder, including demographic	Yes	Actuarial Memo
	Premium	changes such as aging.		
	Increase			
12	Average Renewal	Calculate the average renewal rate increase, weighted by		
	Rate Increase for	written premium, for renewals in the year ending with the	Yes	Actuarial Memo
	a Year	effective period of the rate filing. The calculation must be	4	
		performed for each HIOS product ID.	AND THE PROPERTY AND TH	
13	Rate Change	Rate change history of the forms referenced in the filing. If		
	History	nationwide experience is used in developing the rates, provide	Yes	Actuarial Memo
		separately the rate history for District of Columbia and the		
		nationwide average rate history.		
14	Exposure	Current number of policies, certificates and covered lives.	Yes	Actuarial Memo

Number	Data Element	Requirement Description	Individual and Small Group	ıll Group
			Has the Data Element Been Included?	Location of the Data Element
15	Member Months	Number of members in force during each month of the base experience period used in the rate development and in each of the two preceding twelve-month periods.	Yes	Exhibit A
16	Past Experience	Provide monthly earned premium and incurred claims for the base experience period used in the rate development and each of the two preceding twelve-month periods.	Yes	Exhibit A
7.1	Index Rate	Provide the index rate.	Yes	Actuarial Memo
17.1	Rate Development	Show base experience used to develop rates and all adjustments and assumptions applied to arrive at the requested rates. For less than fully credible blocks, disclose the source of the base experience data used in the rate development and discuss the appropriateness of the data for pricing the policies in the filing.	Yes	Actuarial Memo
18	Credibility Assumption	If the experience of the policies included in the filing is not fully credible, state and provide support for the credibility formula used in the rate development.	Yes	Actuarial Memo
19	Trend Assumption	Show trend assumptions by major types of service as defined by HHS in the Part I Preliminary Justification template, separately by unit cost, utilization, and in total. Provide the development of the trend assumptions.	Yes	Exhibit T
20	Cost-Sharing Changes	Disclose any changes in cost sharing for the plans between the base experience period for rating and the requested effective date. Show how the experience has been adjusted for cost-sharing changes in the rate development. Provide support for the estimated cost impact of the cost-sharing changes.	Yes	Actuarial Memo Exhibít 4
21	Benefit Changes	Disclose any changes in covered benefits for the plans between the base experience period for rating and the requested effective date. Show how the experience has been adjusted for changes in covered benefits in the rate development. Provide support for the estimated cost impact of the benefit changes.	Yės	Actuarial Memo Exhibit 4

Number	Data Element	Requirement Description	Individual and Small Group	1 Group
			Has the Data Element	Location of the
			Been Included?	Data Element
22	Plan Relativities	For rate change filings, if the rate change is not uniform for all plan designs, provide support for all requested rate changes by plan design. Disclose the minimum, maximum, and average impact of the changes on policyholders.	Yes	Actuarial Memo Exhibit 3
		For initial filings, provide the derivation of any new plan factors.		
23	Rating Factors	Provide the age and other rating factors used. Disclose any changes to rating factors, and the minimum, maximum, and average impact on policyholders. Provide support for any changes.	Yes	Actuarial Memo Exhibit 1 Exhibit 3
23.1	Wellness Programs	Describe any wellness programs (as defined in section 2705(j) of the PHS Act) included in this filing.	Yes	Actuarial Memo
24	Distribution of Rate Increases	Anticipated distribution of rate increases due to changes in base rates, plan relativities, and rating factors. This need not include changes in demographics of the individual or group.	Yes	DISB Actuarial Memo Dataset
25	Claim Reserve Needs	Provide the claims for the base experience period separately for paid claims, and estimated incurred claims (including claim reserve). Indicate the incurred period used for the base period. Indicate the paid-through date of the paid claims, and provide a basic description of the reserving methodology for claims reserves and contract reserves, if any. Provide margins used, if any.	Yes	Actuarial Memo Exhibit A Part III Act'l Memo
26	Administrative Costs of Programs that Improve Health Care Quality	Show the amount of administrative costs included with claims in the numerator of the MLR calculation. Show that the amount is consistent with the most recently filed Supplemental Health Care Exhibit or provide support for the difference.	Ύes	Actuarial Memo

		מיל ליסור זיסר ניזיס מיזיסמוני.		
Actuarial Memo	Ύes	Provide rate information relating to the Risk Adjustment program. Information should include assumed Risk Adjustment user fees, Risk Adjustment PMPM excluding user fees and assumed distribution of enrollment by risk score, plan, and geographical area. Provide support for the assumptions, including any demographic changes. Provide information/study on the development of risk scores and Risk Adjustment PMPM. Provide previous year-end estimated risk adjustment payable or receivable amount and quantitative	Risk Adjustment	29
Actuarial Memo	Yes	Demonstrate that the projected loss ratio, including the requested rate change, meets the minimum MLR. Show the premium, claims, and adjustments separately with the development of the projected premium and projected claims (if not provided in the rate development section). If the loss ratio falls below the minimum for the subset of policy forms in the filing, show that when combined with all other policy forms in the market segment in District of Columbia, the loss ratio meets the minimum.	Medical Loss Ratio (MLR)	28
Actuarial Memo	Yes	Show the amount of taxes, licenses, and fees subtracted from premium in the denominator of your medical loss ratio calculation(c). Show that the amount is consistent with the most recently filed Supplemental Health Care Exhibit or provide support for the difference.	Taxes and Licensing or Regulatory Fees	27
Location of the Data Element	Has the Data Element Been Included?			
all Group	Individual/and Small Group	Requirement Description	Data Element	Number

Number	Data Element	Requirement Description	Individual and Small Group	ıll Group
			Has the Data Element Been Included?	Location of the Data Element
30	Past and	Indicate whether loss experience within or outside the state		
	Prospective Loss Experience Within and Outside the State	was used in the development of proposed rates. Provide an explanation for using loss experience within or outside the state.	Yes	Actuarial Memo
31	A Reasonable Margin for Reserve	A Reasonable Show the assumed Margin for Reserve Needs used in the Margin for Reserve Needs		
	Needs	includes factors that reflect assumed contributions to the company's surplus or the assumed profit margin. Demonstrate how this assumption was derived, how the assumption has changed from prior filings, and provide support for changes. If the assumption for Qualified Health Plans exceeds 3% as assumed in the risk corridor formula, justify the excess in light of the company's surplus position.	Ύes	Actuarial Memo

Part I  Rate Summary Worksheet Provide this document with Preliminary Justification (Grandfathered Plan Filings)  Justification (Grandfathered Plan Filings)  Justificed Rate Review Template as specified in the proposed Federal Rate Review regulation. Provide this document value of Federal Rate Review regulation. Provide this document value of Filings)  Justification PDF format.  Part II As CFR § 154.215(f). Provide for all individual and small preliminary and summarizes data elements contained in Actuarial Memorandum Dataset Similar to the Part II Preliminary Justification of the rate increase as specific to description of the rate increase as specific by 45 CFR § Similar to the Part II Preliminary Justification, this is a way and assumptions that were used to develop the proposed provide this document for all individual and small emple and assumptions that were used to develop the proposed provide this document for all individual and small emple group filings.  JISB will require that issuers provide a chart listing a) at all components for the change for each compon such that the total for all components listed equals the tool percentage change requested for the plan year.	Number	Data Element	Requirement Description	Individual and Small Group	ll Group
Part I Preliminary Justification (Grandfathered Plan Filings) Unified Rate Review Template (Non- Grandfathered Filings) Part II Preliminary Justification  DISB Actuarial Memorandum Dataset District of Columbia Plain Language Summary of Components for Requested Rate Change				Has the Data Element Been Included?	Location of the Data Element
Grandfathered Plan Filings) Unified Rate Review Template (Non- Grandfathered Filings) Part II Preliminary Justification  DISB Actuarial Memorandum Dataset District of Columbia Plain Language Summary of Components for Requested Rate Change	36	Part I Preliminary	Rate Summary Worksheet Provide this document with all Grandfathered plan filings. Provide in Excel and PDF	N/a	N/a
(Grandfathered Plan Filings) Unified Rate Review Template (Non-Grandfathered Filings) Part II Preliminary Justification DISB Actuarial Memorandum Dataset District of Columbia Plain Language Summary of Components for Requested Rate Change		Justification	format.	N/a	N/a
Unified Rate Review Template (Non- Grandfathered Filings)  Part II Preliminary Justification  DISB Actuarial Memorandum Dataset  District of Columbia Plain Language Summary of Components for Requested Rate Change		(Grandfathered Plan Filings)			
Review Template (Non- Grandfathered Filings)  Part II Preliminary Justification  DISB Actuarial Memorandum Dataset  District of Columbia Plain Language Summary  Summary of Components for Requested Rate Change	36.1	Unified Rate	Unified Rate Review Template as specified in the proposed		
(Non-Grandfathered Filings) Part II Preliminary Justification  DISB Actuarial Memorandum Dataset  District of Columbia Plain Language Summary of Components for Requested Rate Change		Review Template	Federal Rate Review regulation. Provide this document with		Separate Document
Grandfathered Filings)  Part II Preliminary Justification  DISB Actuarial Memorandum Dataset  District of Columbia Plain Language Summary of Components for Requested Rate Change		(Non-	all Non-Grandfathered plan filings. Provide in Excel and	Yes	in SERFF
Filings) Part II Preliminary Justification  DISB Actuarial Memorandum Dataset  District of Columbia Plain Language Summary  Summary of Components for Requested Rate Change		Grandfathered	PDF format.		
Part II Preliminary Justification  DISB Actuarial Memorandum Dataset  District of Columbia Plain Language Summary  Summary of Components for Requested Rate Change		Filings)			
Justification  DISB Actuarial Memorandum Dataset  District of Columbia Plain Language Summary  Summary of Components for Requested Rate Change	37	Part II Preliminary	Written description justifying the rate increase as specified by 45 CFR § 154.215(f). Provide for <i>all</i> individual and small	<b>₹</b>	Separate Document
DISB Actuarial Memorandum Dataset  District of Columbia Plain Language Summary  Summary of Components for Requested Rate Change		Justification	employer group filings (whether or not they are "subject to	3	in SERFF
Memorandum Dataset  District of Columbia Plain Language Summary  Summary of Components for Requested Rate Change	38	DISB Actuarial	Summarizes data elements contained in Actuarial		
Dataset  District of Columbia Plain Language Summary  Summary of Components for Requested Rate Change	,	Memorandum	Memorandum. Provide this document with all Non-	Ύes	Separate Document
District of Columbia Plain Language Summary  Summary of Components for Requested Rate Change		Dataset	Grandfathered plan filings. Provide in Excel format only.		in SERFF
Columbia Plain Language Summary  Summary of Components for Requested Rate Change	39	District of	Similar to the Part II Preliminary Justification, this is a written		
Summary of Components for Requested Rate Change		Columbia Plain Language	154.215, but as a simple and brief narrative describing the data		Separate Document
Summary of Components for Requested Rate Change		Summary	and assumptions that were used to develop the proposed rates.	Yes	in SERFF
Summary of Components for Requested Rate Change		•	Provide this document for all individual and small employer		
Summary of Components for Requested Rate Change			group filings.		
ents for ed Rate	40	Summary of	DISB will require that issuers provide a chart listing a) any and		
ed Kate		Components for	all components of requested rate changes from the prior year;		
		Requested Rate	b) a quick summary/explanation of the change; and c) the	Yes	Exhibit 3
		Change	actual percentage impact of the change for each component,		
percentage change requested for the plan year.		Í	such that the total for all components listed equals the total		
-			percentage change requested for the plan year.		

Number	Data Element	Requirement Description	Individual and Small Group	all Group
			Has the Data Element	Location of the
41	CCIIO Risk	Received directly from CCIIO; this report should be completed		
	Adjustment	and submitted by the set deadline for QHP submissions, or by		
	Transfer	April 30th of the current year, whichever is first.	Yes	Actuarial Memo
	Elements Extract			
	(RATE 'E')			
42	Additional	Provide the following for stand-alone dental plan filings:		
	Requirements for	<ul> <li>Identification of the level of coverage (i.e. low or</li> </ul>		
	Stand-Alone	high), including the actuarial value of the plan		
	Dental Plan	determined in accordance with the proposed		
	Filings	rule;	N/a	Na
		<ul> <li>Certification of the level of coverage by a member</li> </ul>		
		of the American Academy of Actuaries using		
		generally accepted actuarial principles; and		
		<ul> <li>Demonstration that the plan has a reasonable</li> </ul>		
		annual limitation on cost-sharing.		

# CERTIFYING SIGNATURE

(Print Name)	Ryan Mogan	checklist have been included in the	The undersigned representative of
(Signature)	Myman	checklist have been included in the filing to the best of the company's ability.	The undersigned representative of the organization submitting this rate filing attests t
	more		ests that all items contained in the above

Ryan Morgan
(Print Name)

Page Number	Tracking Number	Plan Name	Run Number	Run AV	Run Weight	Final AV	Final Metal Level
2	Gold 07 CH+ -2019	BH-EY	1	81.9%	100%	81.9%	Gold
3	Gold 1 CH - 2019 on b	BH-EZ	1	80.4%	100%	80.4%	Gold
4	Bronze 04 CH -2019	BH-E3	1	61.3%	100%	61.3%	Bronze
5	Gold 22_Copay CH+ -2019	BH-E4	1	77.9%	70%	79.7%	Gold
6	Gold 22 Copay CH+ -2019	BH-E4	2	83.9%	30%	79.7%	Gold
7	Plat 14 CH+ -2019	BH-E5	1	89.5%	51%	91.4%	Platinum
8	Plat 14 CH+ -2019	BH-E5	2	93.3%	49%	91.4%	Platinum
9	Gold 1 CH+ - 2019 on	BH-E6	1	80.4%	100%	80.4%	Gold
10	Gold 22_Copay CH -2019	BH-E7	1	77.9%	70%	79.7%	Gold
11	Gold 22_Copay CH -2019	BH-E7	2	83.9%	30%	79.7%	Gold
12	Gold 23 CH_Primary Preferred - 2019	BH-FE	1	78.8%	100%	78.8%	Gold
13	Gold 23 CH+_Primary Preferred - 2019	BH-FF	1	78.8%	100%	78.8%	Gold
14	Silver 18_CH Primary Preferred - 2019	BH-FH	1	71.7%	100%	71.7%	Silver
15	Silver 18 CH+ Primary Preferred - 2019	BH-FI	1	71.7%	100%	71.7%	Silver
16	Gold 08 CH+ -2019	BH-FM	1	81.4%	20%	80.7%	Gold
17	Gold 08 CH+ -2019	BH-FM	2	80.0%	41%	80.7%	Gold
18	Gold 08 CH+ -2019	BH-FM	3	81.1%	39%	80.7%	Gold
19	Gold 08 CH -2019	BH-FN	1	81.4%	20%	80.7%	Gold
20	Gold 08 CH -2019	BH-FN	2	80.0%	41%	80.7%	Gold
21	Gold 08 CH -2019	BH-FN	3	81.1%	39%	80.7%	Gold
22	Gold 13 CH+ -2019	BH-FQ	1	83.4%	20%	81.2%	Gold
23	Gold 13 CH+ -2019	BH-FQ	2	78.7%	41%	81.2%	Gold
24	Gold 13 CH+ -2019	BH-FQ	3	82.5%	39%	81.2%	Gold
25	Gold 13 CH -2019	BH-FR	1	83.4%	20%	81.2%	Gold
26	Gold 13 CH -2019	BH-FR	2	78.7%	41%	81.2%	Gold
27	Gold 13 CH -2019	BH-FR	3	82.5%	39%	81.2%	Gold
28	Gold 26 CH+ - 2019	BH-FS	1	76.0%	9%	76.3%	Gold
29	Gold 26 CH+ - 2019	BH-FS	2	78.0%	8%	76.3%	Gold
30	Gold 26 CH+ - 2019	BH-FS	3	76.1%	2%	76.3%	Gold
31	Gold 26 CH+ - 2019	BH-FS	4	78.2%	1%	76.3%	Gold
32	Gold 26 CH+ - 2019	BH-FS	5	74.6%	35%	76.3%	Gold
33	Gold 26 CH+ - 2019	BH-FS	6	77.6%	33%	76.3%	Gold
34	Gold 26 CH+ - 2019	BH-FS	7	74.7%	6%	76.3%	Gold
35	Gold 26 CH+ - 2019	BH-FS	8	77.8%	6%	76.3%	Gold
36	Silver 08 CH+ -2019	BH-FT	1	70.1%	1%	71.0%	Silver
37	Silver 08 CH+ -2019	BH-FT	2	71.9%	1%	71.0%	Silver
38	Silver 08 CH+ -2019	BH-FT	3	71.1%	9%	71.0%	Silver
39	Silver 08 CH+ -2019	BH-FT	4	71.1%	9%	71.0%	Silver
40	Silver 08 CH+ -2019	BH-FT	5	69.5%	6%	71.0%	Silver
41	Silver 08 CH+ -2019	BH-FT	6	71.1%	74%	71.0%	Silver
42	Silver 11 CH+ -2019	BH-FU	1	72.8%	17%	71.1%	Silver
43	Silver 11 CH+ -2019	BH-FU	2	73.1%	3%	71.1%	Silver
44	Silver 11 CH+ -2019	BH-FU	3	69.2%	35%	71.1%	Silver
45	Silver 11 CH+ -2019	BH-FU	4	72.1%	33%	71.1%	Silver
46	Silver 11 CH+ -2019	BH-FU	5	69.4%	6%	71.1%	Silver
47	Silver 11 CH+ -2019	BH-FU	6	72.3% 76.0%	6%	71.1%	Silver
48 49	Gold 26 CH - 2019 Gold 26 CH - 2019	BH-FV BH-FV	1 2	76.0% 78.0%	9% 8%	76.3%	Gold Gold
50	Gold 26 CH - 2019 Gold 26 CH - 2019	BH-FV	3	76.0%	2%	76.3% 76.3%	Gold
51	Gold 26 CH - 2019	BH-FV	4	78.2%	1%	76.3%	Gold
52	Gold 26 CH - 2019	BH-FV	5	74.6%	35%	76.3%	Gold
53	Gold 26 CH - 2019	BH-FV	6	77.6%	33%	76.3%	Gold
54	Gold 26 CH - 2019	BH-FV	7	74.7%	6%	76.3%	Gold
55	Gold 26 CH - 2019	BH-FV	8	77.8%	6%	76.3%	Gold
56	Platinum 01 CH+ -2019	BH-FW	1	89.6%	20%	88.8%	Platinum
57	Platinum 01 CH+ -2019	BH-FW	2	88.0%	41%	88.8%	Platinum
58	Platinum 01 CH+ -2019	BH-FW	3	89.1%	39%	88.8%	Platinum
59	Gold 10 CH+ -2019	BH-FX	1	82.5%	20%	81.2%	Gold
60	Gold 10 CH+ -2019	BH-FX	2	79.8%	41%	81.2%	Gold
61	Gold 10 CH+ -2019	BH-FX	3	82.0%	39%	81.2%	Gold
62	Silver 08 CH -2019	BH-FY	1	70.1%	1%	71.0%	Silver
63	Silver 08 CH -2019	BH-FY	2	71.9%	1%	71.0%	Silver
64	Silver 08 CH -2019	BH-FY	3	71.1%	9%	71.0%	Silver
65	Silver 08 CH -2019	BH-FY	4	71.1%	9%	71.0%	Silver
66	Silver 08 CH -2019	BH-FY	5	69.5%	6%	71.0%	Silver
67	Silver 08 CH -2019	BH-FY	6	71.1%	74%	71.0%	Silver
68	Silver 11 CH -2019	BH-FZ	1	72.8%	17%	71.1%	Silver
69	Silver 11 CH -2019	BH-FZ	2	73.1%	3%	71.1%	Silver
70	Silver 11 CH -2019	BH-FZ	3	69.2%	35%	71.1%	Silver
71	Silver 11 CH -2019	BH-FZ	4	72.1%	33%	71.1%	Silver
72	Silver 11 CH -2019	BH-FZ	5	69.4%	6%	71.1%	Silver
73	Silver 11 CH -2019	BH-FZ	6	72.3%	6%	71.1%	Silver
74	Platinum 01 CH -2019	BH-F2	1	89.6%	20%	88.8%	Platinum
75	Platinum 01 CH -2019	BH-F2	2	88.0%	41%	88.8%	Platinum
76	Platinum 01 CH -2019	BH-F2	3	89.1%	39%	88.8%	Platinum
77	Platinum 04 CH+ -2019	BH-F3	1	90.2%	20%	87.8%	Platinum
78	Platinum 04 CH+ -2019	BH-F3	2	84.7%	41%	87.8%	Platinum
79	Platinum 04 CH+ -2019	BH-F3	3	89.6%	39%	87.8%	Platinum
80	Platinum 04 CH -2019	BH-F5	1	90.2%	20%	87.8%	Platinum
81	Platinum 04 CH -2019	BH-F5	2	84.7%	41%	87.8%	Platinum
82	Platinum 04 CH -2019	BH-F5	3	89.6%	39%	87.8%	Platinum

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?	✓		HSA/HRA Options	5	Tie	red Network Op	tion			
Apply Inpatient Copay per Day?		HSA/HRA Empl	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:		1st	Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Ailidai Coiltii	oution Amount.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_						
		1 Plan Benefit De				2 Plan Benefit D				
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)			\$1,500.00							
Coinsurance (%, Insurer's Cost Share)			100.00%	_						
MOOP (\$)			\$3,000.00			1				
MOOP if Separate (\$)							l			
Click Here for Important Instructions		Tie	or 1			Ti	er 2		Tier 1	Tier 2
Click Here for Important instructions	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible
Medical	✓ All	□ All	unierent	зерагате	□ All	All	unierent	separate	☐ All	□ All
Emergency Room Services	<b>V</b>			\$250.00					<b>V</b>	
All Inpatient Hospital Services (inc. MH/SUD)	<u> </u>	☑		7230.00		Ī				
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	>	✓								
Specialist Visit	V	✓								
Mental/Behavioral Health and Substance Use Disorder Outpatient						· · · · · · · · · · · · · · · · · · ·				
Services	Y	✓								
Imaging (CT/PET Scans, MRIs)	V	✓								
Speech Therapy	V	V								
	V	V								
Occupational and Physical Therapy	· ·	•								
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	V	V								
X-rays and Diagnostic Imaging	Y	✓								
Skilled Nursing Facility	>	✓								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	•	•								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	<b>✓</b> All	☐ All			☐ All	☐ All			<b>☑</b> All	☐ All
Generics	>			\$10.00					V	
Preferred Brand Drugs	>			\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	Y			\$120.00					~	
Options for Additional Benefit Design Limits:			Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-EY						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC0010000	5-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):  Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of	П									
Copays?	_									
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	ful.								
	81.87%									
Metal Tier:	Gold									
	NOTE: One or more	services are not	subject to the ded	uctible and have no	copay. Any ser	vice with this co	st-sharing structure	e is covered at	100% by the plan in	he deductible
Additional Notes:	range.									
Calculation Time:	0.0625 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?	✓		HSA/HRA Options	5	Tie	red Network Op	tion			
Apply Inpatient Copay per Day?		HSA/HRA Empl	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		7 umaar contin	oution, anount.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier					_					
	Medical	1 Plan Benefit De	Combined	+		2 Plan Benefit D				
Deductible (\$)	iviedicai	Drug	\$1,400.00		Medical	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)			90.00%							
MOOP (\$)			\$3,500.00	1		-				
MOOP if Separate (\$)			\$3,500.00	4						
			•							
Click Here for Important Instructions		Tie	er 1			Tie	er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
туре от венени	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	<b>☑</b> All	<b>✓</b> All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	V	✓								
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	✓	•								
Specialist Visit	V	V								
Mental/Behavioral Health and Substance Use Disorder Outpatient	V	<b>V</b>								
Services	L				_	_				
Imaging (CT/PET Scans, MRIs)	V	V								
Speech Therapy	V	V								
	✓	✓								
Occupational and Physical Therapy						_				
Preventive Care/Screening/Immunization	<u> </u>									
Laboratory Outpatient and Professional Services  X-rays and Diagnostic Imaging	V	V								
Skilled Nursing Facility	✓	✓				H				H
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	_								
Outpatient Surgery Physician/Surgical Services	V	<b>V</b>								
Drugs	✓ AII	□ All			☐ All	All			✓ All	All
Generics	V			\$10.00					<u> </u>	
Preferred Brand Drugs	V			\$40.00					<u> </u>	
Non-Preferred Brand Drugs	<ul><li>✓</li></ul>			\$75.00					<b>V</b>	
Specialty Drugs (i.e. high-cost)  Options for Additional Benefit Design Limits:	<u> </u>		Plan Description:	\$120.00						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-EZ						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004006	1-01					
Set a Maximum Number of Days for Charging an IP Copay?	П		Issuer HIOS ID:	41842	101					
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate	Calaulatia a Cui	61								
Status/Error Messages:	Calculation Success	rui.								
Actuarial Value: Metal Tier:	80.44% Gold									
INICIAI TICI.		services are not	subject to the dedi	uctible and have no	conav Anvser	vice with this co	st-sharing structure	is covered at	100% by the plan in	the deductible
Additional Notes:	range.	Services are HUL:	subject to the deal	actible and nave no	copay. Any ser	vice with this to:	or onaring orrutture	. is covered at	. 100/0 by the piditill	inc deductible
radiconal Hotes.	<b>U</b> -									

0.0312 seconds

Final 2019 AV Calculator

Calculation Time:

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?	✓		HSA/HRA Options	s	Tie	red Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:		1st	Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Allitual Colletti	bution Amount.		2nc	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	✓									
Desired Metal Tier	Bronze ▼			_						
	Tie	r 1 Plan Benefit De	esign		Tier	2 Plan Benefit D	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)			\$6,700.00							
Coinsurance (%, Insurer's Cost Share)			100.00%							
MOOP (\$)			\$6,700.00							
MOOP if Separate (\$)										
		_			ı		-		I	
Click Here for Important Instructions			er 1				er 2		Tier 1	Tier 2
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only	after deductible
Medical	✓ All	✓ All	unierent	separate	All	□ All	uniterent	separate	□ All	☐ All
Emergency Room Services	<u> </u>	<u> </u>								
All Inpatient Hospital Services (inc. MH/SUD)	<b>▽</b>	V								
All inpatient hospital services (inc. Mn/SOD)	V	•								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	•	•								
Specialist Visit	V	V								
Mental/Behavioral Health and Substance Use Disorder Outpatient	_								_	
Services	V	$\checkmark$								
Imaging (CT/PET Scans, MRIs)	V	<b>V</b>								
Speech Therapy	✓	<b>V</b>								
	V	✓				П				
Occupational and Physical Therapy	0				_	_				_
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	V	V								
X-rays and Diagnostic Imaging	V	✓								
Skilled Nursing Facility	<b>V</b>	V								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<b>v</b>	<b>V</b>								
Outpatient Surgery Physician/Surgical Services	V	✓								
Drugs	✓ All	✓ All			□ All	□ All			□ All	□ All
Generics	✓ All	V All								
Preferred Brand Drugs	<u>v</u>	V								
	<u>v</u>	V								
Non-Preferred Brand Drugs	<u>v</u>	<u> </u>								
Specialty Drugs (i.e. high-cost)	V	•	Dlan Description		Ш					
Options for Additional Benefit Design Limits:  Set a Maximum on Specialty Rx Coinsurance Payments?		1	Plan Description: Name:	: BH-E3						
Specialty Rx Coinsurance Payments?  Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC0040008	0.01					
Set a Maximum Number of Days for Charging an IP Copay?					8-01					
			Issuer HIOS ID:	41842						
# Days (1-10):  Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):  Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays? # Copays (1-10):										
Output # Copays (1-10).										
Calculate										
Status/Error Messages:	Expanded Bronze	Standard (56% to 6	55%), Calculation Si	uccessful.						
	61.30%	<b>(</b>								
	Bronze									
		e services are not	subject to the ded	uctible and have no	copay. Any ser	vice with this co	st-sharing structure	e is covered at	100% by the plan in t	he deductible
	range.		,							
Additional Motes.	0									
Calculation Time:	0.0625 seconds									
Calculation Time.	0.0023 30001103									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	}	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?	✓	HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Aimai contin	bation Amount.		2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_	_					
		1 Plan Benefit De	1	_		2 Plan Benefit I				
Deductible (\$)	Medical \$0.00	<b>Drug</b> \$0.00	Combined	-	Medical	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$7,90			•						
MOOP if Separate (\$)		0.00		-						
			•							
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
- (- (-	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	C	- 60
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	arter deductible
Medical	☐ All	☐ All			☐ All	All			☐ All	All
Emergency Room Services				\$500.00						
All Inpatient Hospital Services (inc. MH/SUD)				\$1,000.00						
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Timilary care visit to fredt arrinjary of finess (e.k.: Freventive, and x rays)										
Specialist Visit				\$60.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00						
Services				4200.00						
Imaging (CT/PET Scans, MRIs)				\$300.00 \$30.00						
Speech Therapy				\$30.00						
Occupational and Physical Therapy				\$30.00						
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services				\$60.00						
X-rays and Diagnostic Imaging				\$60.00						
Skilled Nursing Facility				\$1,000.00						
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)				\$600.00						
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$50.00						
Non-Preferred Brand Drugs				\$100.00						
Specialty Drugs (i.e. high-cost)				\$50.00						
Options for Additional Benefit Design Limits:			Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name: Plan HIOS ID:	BH-E4 41842DC0010078	0.01					
Specialty Rx Coinsurance Maximum:  Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	4184200010078	5-01					
# Days (1-10):			issuer HIOS ID:	41642						
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output  Calculate										
Status/Error Messages:	Calculation Success	sful.								
Actuarial Value:	77.93%									
Metal Tier:	Gold									
	NOTE: Service-spec	ific cost-sharing is	s applying for servi	ce(s) with fac/prof	components, ov	verriding outpation	ent inputs for those	service(s).		
Additional Notes:						·				
Calculation Time:	0.0273 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Empl	oyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contrib	oution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		u 1 Dlaw Dawafit Da	alau.	_	Tion	2 Dlaw Banafit F	Nacion .			
	Medical	r 1 Plan Benefit De Drug	Combined		Medical	2 Plan Benefit Drug	Combined			
Deductible (\$)	\$0.00	\$0.00	Combined		ivieuicai	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)		00.00		Ī		1				
MOOP if Separate (\$)				-						
			_							
Click Here for Important Instructions		Tie					er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies onl	v after deductible
	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☐ All	☐ All			All	☐ All			☐ All	☐ All
Emergency Room Services				\$500.00						
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Constitution (Constitution)				÷50.00						
Specialist Visit  Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00						
Services				\$60.00						
Imaging (CT/PET Scans, MRIs)				\$300.00						
Speech Therapy				\$30.00						
Occupational and Physical Therapy	Ш	Ш		\$30.00						
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services				\$60.00						
X-rays and Diagnostic Imaging				\$60.00						
Skilled Nursing Facility				\$1,000.00						
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	•	•								
	<b>V</b>	✓								
Outpatient Surgery Physician/Surgical Services	☐ All	□ All			□ All	□ All			□ □ All	
Drugs Generics		□ All		\$10.00						□ All
Preferred Brand Drugs				\$50.00						
Non-Preferred Brand Drugs				\$100.00						
Specialty Drugs (i.e. high-cost)				\$50.00						
Options for Additional Benefit Design Limits:			Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-E4						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC0010078	8-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):  Begin Primary Care Deductible/Coinsurance After a Set Number of										
Regin Primary Care Deductible/Coinsurance After a Set Number of Copays?										
# Copays (1-10):										
Output		J								
Calculate										
	Error: Result is out	side of [-4, +2] per	cent de minimis va	ariation.						
	83.85%									
Metal Tier:										
Additional Notes:										
Calculation Time:	0.0391 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			<b>HSA/HRA Option</b>		1	ered Network O				
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? □		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		1 Plan Benefit De	alau.	_	Ties	· 2 Plan Benefit I	Danier			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)		\$0.00	Combined		ivicuicai	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$3,00					1				
MOOP if Separate (\$)				-						
			_				_			
Click Here for Important Instructions		Tie	er 1			Ti	ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	y after deductible?
••	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services				\$200.00						
All Inpatient Hospital Services (inc. MH/SUD)										
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$10.00						
Constitution Mark				ć20.00						
Specialist Visit  Mental/Behavioral Health and Substance Use Disorder Outpatient				\$20.00						
Services				\$20.00						
Imaging (CT/PET Scans, MRIs)				\$150.00						
Speech Therapy				\$10.00						
										_
Occupational and Physical Therapy				\$10.00						
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services										
X-rays and Diagnostic Imaging										
Skilled Nursing Facility		V								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)				\$150.00						
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$40.00						
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name: Plan HIOS ID:	BH-E5 41842DC001007	4.01					
Specialty Rx Coinsurance Maximum:  Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842DC001007	4-01					
# Days (1-10):			issuel filos ib.	41042						
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	sful.								
Actuarial Value:	89.46%									
Metal Tier:	Platinum	office and a short of								
A Life Land	NOTE: Service-spec	CITIC COST-Sharing is	s applying for servi	ice(s) with fac/prof	components, ov	verriding outpati	ent inputs for those	service(s).		
Additional Notes:										
Calculation Time:	0.043 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options		Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Empl	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:		15	t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Allitual Colletti	button Amount.		2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier										
		r 1 Plan Benefit De	1			2 Plan Benefit D				
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$0.00	\$0.00								
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%		-						
MOOP (\$)		00.00		-						
MOOP if Separate (\$)							l			
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible
Medical	☐ All	☐ All		·	All	☐ All			□ All	☐ All
Emergency Room Services				\$200.00						
All Inpatient Hospital Services (inc. MH/SUD)										
	_	_		***						
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$10.00						
Specialist Visit				\$20.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$20.00	_	_				_
Services				\$20.00						
Imaging (CT/PET Scans, MRIs)				\$150.00						
Speech Therapy				\$10.00						
				\$10.00						
Occupational and Physical Therapy				ψ20.00					_	
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services										
X-rays and Diagnostic Imaging										
Skilled Nursing Facility		✓								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	All	— □ All			□ All	— □ All			□ All	
Generics				\$10.00					-	
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$40.00						
Options for Additional Benefit Design Limits:			Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-E5						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC0010074	1-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of	Ш									
Copays? # Copays (1-10):										
Output										
Calculate										
	Error: Result is out	side of [-4. +2] ner	cent de minimis va	riation.						
	93.33%	o. [ ., .z] pci	22 GC							
Metal Tier:										
Additional Notes:										
Calculation Time:	0.0547 seconds									
Final 2019 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?	•		HSA/HRA Option	s	Tie	red Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiered	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:		1st	Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Annual Contin	bution Amount.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				=						
		1 Plan Benefit De				2 Plan Benefit I				
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)			\$1,400.00							
Coinsurance (%, Insurer's Cost Share)			90.00%	+						
MOOP (\$)			\$3,500.00			T				
MOOP if Separate (\$)							l			
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible
Medical	✓ All	✓ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	<b>V</b>	✓								
All Inpatient Hospital Services (inc. MH/SUD)	✓	✓								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	V	<b>V</b>								
	_	_ ✓								
Specialist Visit	V	<u> </u>								<u> </u>
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	V	✓								
Imaging (CT/PET Scans, MRIs)	V	V								
Speech Therapy	v	V								
Occupational and Discipal Theorem	V	<b>V</b>								
Occupational and Physical Therapy Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services		✓								
X-rays and Diagnostic Imaging	V	<u>v</u>			H	Ä				
Skilled Nursing Facility	<b>V</b>	<b>▽</b>								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	V								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	<b>☑</b> All	☐ All			☐ All	☐ All			✓ All	☐ All
Generics	<u> </u>			\$10.00					<u>v</u>	
Preferred Brand Drugs	<u> </u>			\$40.00					_	
Non-Preferred Brand Drugs	N [			\$75.00					<u> </u>	
Specialty Drugs (i.e. high-cost)	V			\$120.00					✓	
Options for Additional Benefit Design Limits:		Ì	Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-E6 41842DC001008	1 01					
Specialty Rx Coinsurance Maximum:  Set a Maximum Number of Days for Charging an IP Copay?			Plan HIOS ID: Issuer HIOS ID:	41842	1-01					
# Days (1-10):			issuer nios ib:	41842						
Begin Primary Care Cost-Sharing After a Set Number of Visits?	П									
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output		•								
Calculate										
Status/Error Messages:	Calculation Succes	sful.								
Actuarial Value:	80.44%									
Metal Tier:	Gold									
	NOTE: One or mor	e services are not	subject to the ded	uctible and have no	copay. Any ser	vice with this co	st-sharing structure	e is covered at	100% by the plan in	the deductible
Additional Notes:	range.									
Calculation Time:	0.0312 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Options			ered Network Op				
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?	-				2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		4 Dl D 6't D-	-1	П	T1	2 Dl D 6'4 F	D			
	Medical	1 Plan Benefit De Drug	Combined	+	Medical	2 Plan Benefit I Drug	Combined			
Deductible (\$)	\$0.00	\$0.00	Combined		ivieuicai	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)		100.00%								
MOOP (\$)	\$7,90					1				
MOOP if Separate (\$)				-						
							-			
Click Here for Important Instructions		Tie	er 1			Ti	ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Conav annlies onl	y after deductible?
	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		·
Medical	☐ All	☐ All			☐ All	All			☐ All	☐ All
Emergency Room Services				\$500.00						
All Inpatient Hospital Services (inc. MH/SUD)				\$1,000.00						
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit	Ш			\$60.00					Ш	
Mental/Behavioral Health and Substance Use Disorder Outpatient Services				\$60.00						
Imaging (CT/PET Scans, MRIs)				\$300.00						
Speech Therapy				\$30.00						
Occupational and Physical Therapy				\$30.00						
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services				\$60.00						
X-rays and Diagnostic Imaging				\$60.00						
Skilled Nursing Facility				\$1,000.00						
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)				\$600.00						
				Ç000.00						_
Outpatient Surgery Physician/Surgical Services	V	<b>V</b>								
Drugs	□ AII	□ All			☐ All	All			□ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$50.00						_
Non-Preferred Brand Drugs				\$100.00						
Specialty Drugs (i.e. high-cost)  Options for Additional Benefit Design Limits:			Plan Description:	\$50.00	ш	Ш				Ш
Set a Maximum on Specialty Rx Coinsurance Payments?	П		Name:	BH-E7						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004005	7-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842	, 01					
# Days (1-10):	3			12012						
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate	Coloulation Sur-	£l								
Status/Error Messages:	Calculation Success	tul.								
Actuarial Value: Metal Tier:	77.93% Gold									
ivictal fiel.	NOTE: Service-spec	ific cost-sharing is	s anniving for servi	ce(s) with fac/prof	components	verriding outpatie	ent innuts for those	service(s)		
Additional Notes:	NOTE. Service-spec	inc cost-snailigi	applying for servi	cc(3, with rac/prof	components, o	remains outpath	chemputs for those	. JCI VICE(3).		
Additional Notes.										
Calculation Time:	0.0312 seconds									
Calculation Time:	U.U312 Seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			<b>HSA/HRA Options</b>	5	Tie	ered Network O	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?	✓	Annual Cantril	bution Amount:		1s <sup>-</sup>	t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Annual Contri	bution Amount:		2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?					•					
Desired Metal Tier	Gold ▼									
	Tie	r 1 Plan Benefit De	sign		Tier	2 Plan Benefit I	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$0.00	\$0.00								
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$7,90	00.00				•				
MOOP if Separate (\$)				-						
		•	-			•	-			
Click Here for Important Instructions		Tie	er 1			Ti	ier 2		Tier 1	Tier 2
Town of Donnella	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Canau annliae anh	. aftau dad. atible
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	arter deductible
Medical	☐ All	☐ All			☐ All	All			□ All	_ All
Emergency Room Services				\$500.00						
All Inpatient Hospital Services (inc. MH/SUD)	>	✓								
	_	_		4						
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit				\$60.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient									***************************************	
Services				\$60.00						
Imaging (CT/PET Scans, MRIs)				\$300.00						
Speech Therapy				\$30.00						
		······································								
Occupational and Physical Therapy				\$30.00						
Preventive Care/Screening/Immunization	П	П				П				
Laboratory Outpatient and Professional Services				\$60.00		_				
X-rays and Diagnostic Imaging				\$60.00						
Skilled Nursing Facility				\$1,000.00						
Skilled Nulsing Facility		······································		\$1,000.00						
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓								
Outpotient Surgery Physician / Surgical Services	V	V				П				
Outpatient Surgery Physician/Surgical Services	□ All	□ All			□ All	□ All			□ All	□ All
Drugs				\$10.00	□ All				All	
Generics Description of Description										
Preferred Brand Drugs				\$50.00						
Non-Preferred Brand Drugs				\$100.00						
Specialty Drugs (i.e. high-cost)	Ш		Dian Danishton	\$50.00		Ш				Ш
Options for Additional Benefit Design Limits:		1	Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?	П		Name:	BH-E7	7.04					
Specialty Rx Coinsurance Maximum:			Plan HIOS ID: Issuer HIOS ID:	41842DC004005 41842	7-01					
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	П		issuer HIOS ID:	41842						
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):  Begin Primary Care Deductible/Coinsurance After a Set Number of										
	Ш									
Copays? # Copays (1-10):										
Output Calculate										
	Funcio Describio eco	da af [ 4 . 2] man		, viatio u						
	Error: Result is out 83.85%	siue 01 [-4, +2] per	cent de minimis va	matiOn.						
	83.85%									
Metal Tier:										
Additional Notes:										
Calculation Time:	0.0508 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?	· 🗆		HSA/HRA Options		Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?	· 🗆	HSA/HRA Emp	loyer Contribution?	? 🗆	Tiere	d Network Plan?	V			
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Aimai contr	button Amount.		2nd	d Tier Utilization:	53%			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_	_					
		1 Plan Benefit De		-		2 Plan Benefit [				
Deductible (\$)	Medical \$1,000.00	<b>Drug</b> \$250.00	Combined		\$1,000.00	<b>Drug</b> \$250.00	Combined			
Coinsurance (%, Insurer's Cost Share)		100.00%			80.00%	100.00%				
MOOP (\$)				1		900.00				
MOOP if Separate (\$)				-	41,5					
			-			•				
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
· ·	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	V	<u> </u>	50%		<u> </u>	<u> </u>	50%			
All Inpatient Hospital Services (inc. MH/SUD)	V	V			V	V				
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)		•	100%			<b>~</b>	100%			
				A== ==				400.00		
Specialist Visit  Mental/Behavioral Health and Substance Use Disorder Outpatient				\$55.72				\$80.00		
Services		~	100%			~	100%			
Imaging (CT/PET Scans, MRIs)				\$500.00				\$500.00		
Speech Therapy	v	☑			<u> </u>	<u> </u>				
	<u> </u>	✓			v	✓				
Occupational and Physical Therapy	<b>⊻</b>	<b>∠</b>			_	V				Ш
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services				\$40.00				\$40.00		
X-rays and Diagnostic Imaging				\$40.00				\$40.00		
Skilled Nursing Facility	V	V			V	V				
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<b>V</b>	V			✓	✓				
Outpatient Surgery Physician/Surgical Services	✓	☑			v	V				
Drugs	□ All	□ All			□ All	□ All			□ All	□ All
Generics				\$5.00				\$5.00		
Preferred Brand Drugs	☑			\$40.00	2			\$40.00	<u> </u>	✓
Non-Preferred Brand Drugs	✓			\$75.00	V			\$75.00	V	✓
Specialty Drugs (i.e. high-cost)	V			\$120.00	v			\$120.00	V	✓
Options for Additional Benefit Design Limits:			Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-FE						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC0040062	2-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?  # Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	ful.								
Actuarial Value:	78.79%									
Metal Tier:	Gold									
		e services are not	subject to the dedu	uctible and have no	copay. Any sei	rvice with this co	st-sharing structur	e is covered at	100% by the plan in	the deductible
Additional Notes:	range.									
Calculation Time:	0.082 seconds									
Final 2019 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Tie	red Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?	✓			
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		7 miliaar contri	bacion / uno anc.		2nd	l Tier Utilization:	53%			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_						
		r 1 Plan Benefit De				2 Plan Benefit D				
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$1,000.00	\$250.00			\$1,000.00	\$250.00				
Coinsurance (%, Insurer's Cost Share)	80.00%	100.00%			80.00%	100.00%				
MOOP (\$)	\$7,9	00.00			\$7,9	00.00				
MOOP if Separate (\$)							l			
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		6. 1.1
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible
Medical	☐ All	☐ All		·	☐ All	☐ All			□ All	☐ All
Emergency Room Services	<b>V</b>	~	50%		✓	~	50%			
All Inpatient Hospital Services (inc. MH/SUD)	✓	✓			☑	✓				
			4000/				4000/			
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)		✓	100%			✓	100%			
Specialist Visit				\$55.72				\$80.00		
Mental/Behavioral Health and Substance Use Disorder Outpatient Services		•	100%			~	100%			
Imaging (CT/PET Scans, MRIs)				\$500.00				\$500.00		
Speech Therapy	v	v		<b>3300.00</b>	<u> </u>	☑		7500.00		
Specific Control of the Control of t										
Occupational and Physical Therapy	✓	V			✓	✓				
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services				\$40.00				\$40.00		
X-rays and Diagnostic Imaging				\$40.00				\$40.00		
Skilled Nursing Facility	✓	<b>▽</b>		, , , , , ,	✓	✓				
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	✓			v	V				
Outpatient Surgery Physician/Surgical Services	v	V			V	V				
Drugs	□ AII	□ All		<u> </u>	☐ All	□ All		<u>.</u>	□ All	□ All
Generics				\$5.00				\$5.00		
Preferred Brand Drugs	V			\$40.00	<b>V</b>			\$40.00	<u> </u>	V
Non-Preferred Brand Drugs	<b>V</b>			\$75.00	V			\$75.00	<b>V</b>	<b>V</b>
Specialty Drugs (i.e. high-cost)		Ш	Dlan Description	\$120.00				\$120.00	V	
Options for Additional Benefit Design Limits:  Set a Maximum on Specialty Rx Coinsurance Payments?		1	Plan Description: Name:	: BH-FF						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC0010082	2 01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842	2-01					
# Days (1-10):			issuel filos ib.	41042						
Begin Primary Care Cost-Sharing After a Set Number of Visits?	П	-								
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Succes	ssful.								
	78.79%									
Metal Tier:	Gold									
	NOTE: One or mo	re services are not	subject to the dedu	uctible and have no	copay. Any ser	vice with this co	st-sharing structur	e is covered at	100% by the plan in	the deductible
Additional Notes:	range.									
Calculation Time:	0.0781 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	5	Tie	red Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiered	Network Plan	· •			
Apply Skilled Nursing Facility Copay per Day?		Ammund Combail	hti		1st	Tier Utilization	: 47%			
Use Separate MOOP for Medical and Drug Spending?		Annual Contri	bution Amount:		2nd	Tier Utilization	: 53%			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	_				•					
Desired Metal Tier										
	Tier 1	Plan Benefit De	sign		Tier	2 Plan Benefit	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$4,250.00	\$250.00		T .	\$4,250.00	\$250.00				
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%			70.00%	100.00%				
MOOP (\$)	\$7,900					00.00				
MOOP if Separate (\$)	<b>\$1,500</b>	.00		-	<i>\$1,13</i>	00.00				
Woot it separate (5)										
Click Here for Important Instructions		Tie	er 1			т	ier 2		Tier 1	Tier 2
energy reportant management	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?		separate	Copay applies only	after deductible
Medical	☐ All	□ All	unierent	separate	□ All	□ All	uniterent	separate	☐ All	☐ All
	✓ All	✓ All	F00/		✓ All	<u> </u>	F00/			
Emergency Room Services	<u> </u>		50%				50%			
All Inpatient Hospital Services (inc. MH/SUD)	¥	V			V	V				
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)		✓	100%			✓	100%			
Specialist Visit				\$69.65				\$100.00		
Mental/Behavioral Health and Substance Use Disorder Outpatient		✓	100%			✓	100%			
Services			100%		L		10070			
Imaging (CT/PET Scans, MRIs)	<b>&gt;</b>	✓			V	V				
Speech Therapy	V	V			v	V				
	V	V			✓	V				
Occupational and Physical Therapy	·					Ŀ				
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	V	<b>V</b>			V	V				
X-rays and Diagnostic Imaging	>	✓			V	✓				
Skilled Nursing Facility	>	✓			<b>V</b>	✓				
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	✓			✓	V				
Outpatient Surgery Physician/Surgical Services	V	<b>V</b>			v	V				
Drugs	□ All	□ All			☐ All	□ All			☐ All	☐ All
Generics				\$5.00				\$5.00		
Preferred Brand Drugs				\$40.00	v			\$40.00		☑
Non-Preferred Brand Drugs				\$75.00	v			\$75.00		☑
Specialty Drugs (i.e. high-cost)	] 🔽			\$120.00	v			\$120.00	☑ ✓	V
Options for Additional Benefit Design Limits:			Plan Description:					Ç120.00		
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-FH						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC0040063	2 01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842	5-01					
# Days (1-10):			issuel filos ib.	41042						
Begin Primary Care Cost-Sharing After a Set Number of Visits?	_									
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
. 9	Calculation Successf	ul.								
	71.71%									
	Silver									
	NOTE: One or more					vice with this co	st-sharing structure	e is covered at	100% by the plan in	ne deductible
Additional Notes:	range. NOTE: Office	-visit-specific co	st-sharing is applyi	ng to x-rays in offic	e settings.					
Calculation Time:	0.0664 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Tie	red Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan	· •			
Apply Skilled Nursing Facility Copay per Day?		A C	hartina Amazana		1st	Tier Utilization	: 47%			
Use Separate MOOP for Medical and Drug Spending?		Annual Contri	bution Amount:		2nd	Tier Utilization	: 53%			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?							•			
Desired Metal Tier	Silver ▼									
	Tier 1	Plan Benefit De	esign		Tier	2 Plan Benefit	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$4,250.00	\$250.00			\$4,250.00	\$250.00				
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%			70.00%	100.00%				
MOOP (\$)	\$7,900			<b>T</b>		00.00				
MOOP if Separate (\$)				-	7.75					
			_				-			
Click Here for Important Instructions		Tie	er 1			Т	ier 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?		separate	Copay applies only	after deductible
Medical	All	☐ All	uniciciit	эсранис	□ All	□ All	uniterent .	Separate	☐ All	☐ All
Emergency Room Services	<b>V</b>	<u> </u>	50%		<b>V</b>	<u> </u>	50%			
All Inpatient Hospital Services (inc. MH/SUD)	V	<b>V</b>	30/0		v	✓	30/6			
All impatient nospital services (inc. IVII/30D)										Ц
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)		✓	100%			✓	100%			
Constallation of the Constalla				600 CF				Ć400.00		
Specialist Visit				\$69.65	Ш	Ш		\$100.00		
Mental/Behavioral Health and Substance Use Disorder Outpatient		✓	100%			✓	100%			
Services	L									
Imaging (CT/PET Scans, MRIs)	<b>▽</b>	<b>v</b>			<b>V</b>	<b>▽</b>				
Speech Therapy	V	V			V	V				
	✓	•			✓	✓				
Occupational and Physical Therapy										
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	V	V			V	V				
X-rays and Diagnostic Imaging	V	✓			V	~				
Skilled Nursing Facility	V	V			V	V				
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	✓			V	V				
outputient rulinty rec (e.g., Ambulatory Surgery Center)										
Outpatient Surgery Physician/Surgical Services	V	V			V	V				
Drugs	☐ AII	☐ AII			☐ All	☐ All			☐ All	☐ All
Generics				\$5.00				\$5.00		
Preferred Brand Drugs	V			\$40.00	V			\$40.00	V	✓
Non-Preferred Brand Drugs	✓			\$75.00	V			\$75.00	✓	✓
Specialty Drugs (i.e. high-cost)	•			\$120.00	>			\$120.00	✓	✓
Options for Additional Benefit Design Limits:			Plan Description:	•						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-FI						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001008	3-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Successf	ul.								
Actuarial Value:	71.71%									
	Silver									
	NOTE: One or more	services are not	subject to the ded	uctible and have no	copay. Any ser	vice with this co	st-sharing structure	e is covered at	100% by the plan in	the deductible
Additional Notes:	range. NOTE: Office		-				3			
, wasterna, HOLES.	J		- O	J	<del>0-</del> -					
Calculation Times	0.0050									
Calculation Time:	0.0859 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:	s	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		L Plan Benefit De	rian		Tion	· 2 Plan Benefit D	osian			
	Medical	Drug	Combined	+	Medical	Drug	Combined			
Deductible (\$)	\$1,250.00	\$0.00	Combined		Wicalcai	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)	80.00%	100.00%								
MOOP (\$)	\$4,250	0.00								
MOOP if Separate (\$)				-						
									•	
Click Here for Important Instructions		Tie					er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
Medical	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	☐ All	□ All
Emergency Room Services	☑ All	✓ All								
All Inpatient Hospital Services (inc. MH/SUD)	V	✓								
				400.00						
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit				\$60.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00		П				
Services	L				_	_				
Imaging (CT/PET Scans, MRIs) Speech Therapy				\$30.00						
Speculinerapy				\$30.00						
Occupational and Physical Therapy				\$30.00						
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	✓	V								
X-rays and Diagnostic Imaging	V	V								
Skilled Nursing Facility	V	V								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	V								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ AII	☐ All			All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						_
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)  Options for Additional Benefit Design Limits:	Ш	Ш	Plan Description	\$120.00						
Set a Maximum on Specialty Rx Coinsurance Payments?	П		Name:	BH-FM						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001005	4-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):	_									
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays? # Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Successi	ul.								
Actuarial Value:	81.44%									
Metal Tier:	Gold									
	NOTE: One or more		-			rvice with this co	st-sharing structure	is covered at	100% by the plan in	the deductible
Additional Notes:	range. NOTE: Office	e-visit-specific co	st-sharing is applyi	ng to x-rays in offic	ce settings.					
Calculation Time:	0.0469 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:		Tie	ered Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	i? □		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		7 ii ii dan Contan			2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_						
		r 1 Plan Benefit De				2 Plan Benefit I	1 -			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$1,250.00	\$0.00								
Coinsurance (%, Insurer's Cost Share)	80.00%	100.00%								
MOOP (\$)	\$4,2	50.00								
MOOP if Separate (\$)			l							
Click Here for Important Instructions		Tie	1			-	ier 2		Tier 1	Tier 2
Click Here for Important Instructions	Cultinate			C 16	C. I.I. at the			C 16	Her 1	Her Z
Type of Benefit	Subject to Deductible?	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if different	Copay, if	Copay applies only	after deductible
Medical	□ All	Coinsurance?	different	separate	Deductible?	Coinsurance?	amerent	separate	☐ All	☐ All
	✓ All	✓ All				AII			All	AII
Emergency Room Services	<u> </u>	<u> </u>								
All Inpatient Hospital Services (inc. MH/SUD)	<u> </u>	<u>v</u>								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Constitution of the second				¢co.00						П
Specialist Visit	Ш	Ш		\$60.00					Ш	
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00						
Services	V	V	400/	Ć250.00						
Imaging (CT/PET Scans, MRIs) Speech Therapy		~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	49%	\$250.00 \$30.00					<b>2</b>	
эреесп петару				\$30.00						
Occupational and Physical Therapy				\$30.00						
Preventive Care/Screening/Immunization	П									
	✓	<u> </u>								
Laboratory Outpatient and Professional Services X-rays and Diagnostic Imaging	V	V								
, , , , , , , , , , , , , , , , , , , ,	V	<u> </u>								
Skilled Nursing Facility		<u> </u>								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	•	31%	\$250.00						
Outpatient Surgery Physician/Surgical Services	V	V								
	□ All	□ All			□ All	□ All			□ All	□ All
Drugs Generics				\$10.00					All	
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)  Options for Additional Benefit Design Limits:			Dlan Description	\$120.00	Ш					
Set a Maximum on Specialty Rx Coinsurance Payments?		1	Plan Description Name:	BH-FM POST						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001005	4.01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842	4-01					
# Days (1-10):			issuer HIOS ID:	41842						
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of	П									
Copays?										
# Copays (1-10):										
Output		J								
Calculate										
Status/Error Messages:	Calculation Succes	sful.								
	79.98%	-								
	Gold									
		e services are not	subject to the ded	uctible and have no	n conav. Anv se	wice with this co	set_charing etructure	is covered at	100% by the plan in	the deductible
Additional Notes:				ing to x-rays in OTTI	ce secungs. NO	i.e. service-speci	inc cost-snaring is a	philing for sei	vice(s) with fac/prof	components,
	overriding outpati	ent inputs for those	e service(S).							
Calculation Time:	0.0234 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	Gold ▼									
Desired Metal Tier		I Plan Benefit De	scian		Tion	· 2 Plan Benefit D	Nosian			
	Medical	Drug	Combined	+	Medical	Drug	Combined			
Deductible (\$)	\$1,250.00	\$0.00	Combined		ivieuicai	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)	80.00%	100.00%								
MOOP (\$)	\$4,250					1				
MOOP if Separate (\$)				-						
							- · · · · · · · · · · · · · · · · · · ·			
Click Here for Important Instructions		Tie					er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
na disal	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		□ All
Medical	∐ All	☐ All			_	AII			□ All	
Emergency Room Services All Inpatient Hospital Services (inc. MH/SUD)	V	<b>▽</b>								
All impatient hospital services (inc. Willy 300)	E .									
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit				\$60.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient	_			·····	_				_	
Services				\$60.00						
Imaging (CT/PET Scans, MRIs)	V	V	49%	\$250.00						
Speech Therapy				\$30.00						
				\$30.00						
Occupational and Physical Therapy					_					
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	> >	<b>V</b>								
X-rays and Diagnostic Imaging Skilled Nursing Facility	V	<u> </u>								
Skilled Nulsing Facility										
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	•								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$120.00						
Options for Additional Benefit Design Limits:			Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?  Specialty Rx Coinsurance Maximum:			Name: Plan HIOS ID:	BH-FM_POST_ 41842DC0010054	4.01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842	4-01					
# Days (1-10):	<u> </u>		issuel filos ib.	41042						
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):	_									
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate	Calculation Cur	E1								
Status/Error Messages: Actuarial Value:	Calculation Successi 81.05%	ui.								
Metal Tier:	81.05% Gold									
medi nen	NOTE: One or more	services are not	subject to the ded	uctible and have no	copay. Any ser	vice with this co	st-sharing structure	is covered at	100% by the plan in	the deductible
Additional Notes:	range. NOTE: Office		-						, o by the plantin	academore
, additional moces.	Ç		. 0	5 .,	0-					
Calculation Time:	0.0664 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			<b>HSA/HRA Options</b>	5	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:		1st	Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Allitual Colletti	bution Amount.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?							<u>.</u>			
Desired Metal Tier	Gold ▼									
	Tier 1	Plan Benefit De	sign		Tier	2 Plan Benefit D	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$1,250.00	\$0.00								
Coinsurance (%, Insurer's Cost Share)	80.00%	100.00%								
MOOP (\$)	\$4,250	.00								
MOOP if Separate (\$)				<del></del>						
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
Type of Belletic	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	copa, applies om,	
Medical	☐ AII	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	V	~								
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Drimony Core Visit to Treet on Injury or Illness (over Dreventing and Visual)				¢20.00						
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit				\$60.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				¢c0.00	_	_				_
Services				\$60.00						
Imaging (CT/PET Scans, MRIs)	V	✓								
Speech Therapy				\$30.00						
				400.00						
Occupational and Physical Therapy		Ш		\$30.00		Ш				
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	N	V								
X-rays and Diagnostic Imaging	<b>\</b>	V								
Skilled Nursing Facility	>	✓								
					_	_				_
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	✓								
Outpatient Surgery Physician/Surgical Services	V	✓								
Drugs	☐ AII	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$120.00						
Options for Additional Benefit Design Limits:			Plan Description:	:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-FN						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC0040093	1-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
	Calculation Successf	ul.								
Actuarial Value:	81.44%									
Metal Tier:	Gold									
	NOTE: One or more	services are not	subject to the ded	uctible and have no	copay. Any ser	vice with this co	st-sharing structure	is covered at	100% by the plan in	the deductible
Additional Notes:	range. NOTE: Office	-visit-specific co	st-sharing is applyi	ng to x-rays in offic	e settings.					
Calculation Time:	0.0547 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?		Tie	ered Network O <sub>l</sub>	otion						
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:		1s	t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Annual Contin	button Amount.		2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_						
		1 Plan Benefit De	1			2 Plan Benefit I				
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$1,250.00	\$0.00								
Coinsurance (%, Insurer's Cost Share)		100.00%								
MOOP (\$)	\$4,25	0.00								
MOOP if Separate (\$)										
and the second s		_			I	_	_			
Click Here for Important Instructions		Tie					er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
Medical	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	□ All	☐ All
	Ŭ All	✓ All								
Emergency Room Services All Inpatient Hospital Services (inc. MH/SUD)	V	✓								
All Impatient Hospital Services (inc. Min/SOD)		•							Ш	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit				\$60.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				300.00						
Services				\$60.00						
Imaging (CT/PET Scans, MRIs)	V	✓	49%	\$250.00						
Speech Therapy			4570	\$30.00						
Specificacy										
Occupational and Physical Therapy				\$30.00						
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	V									
X-rays and Diagnostic Imaging	☑	<b>V</b>								
Skilled Nursing Facility	✓	<u> </u>								
Skilled (Vd/Sing Lacinty										
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓	31%	\$250.00						
Outpatient Surgery Physician/Surgical Services	☑	✓								
Drugs	□ All	□ All			— All	— — — — — — — — — — — — — — — — — — —			□ All	
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						П
Specialty Drugs (i.e. high-cost)				\$120.00						
Options for Additional Benefit Design Limits:		<del></del>	Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-FN POST						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004009	1-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	ful.								
Actuarial Value:	79.98%									
Metal Tier:	Gold									
	NOTE: One or more	services are not	subject to the ded	uctible and have no	o copay. Any sei	rvice with this co	st-sharing structure	e is covered at	100% by the plan in	the deductible
Additional Notes:				ng to x-rays in offic	ce settings. NO	ΓΕ: Service-speci	fic cost-sharing is a	pplying for se	rvice(s) with fac/prof	components,
	overriding outpatie	nt inputs for those	e service(s).							
Calculation Time:	0.0273 seconds									
Final 2019 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?	_	HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		Plan Benefit De	scian		Tion	· 2 Plan Benefit D	Nosian			
	Medical	Drug	Combined	+	Medical	Drug	Combined			
Deductible (\$)	\$1,250.00	\$0.00	Combined		Wicalcai	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)	80.00%	100.00%								
MOOP (\$)	\$4,250	.00								
MOOP if Separate (\$)				-			·			
									•	
Click Here for Important Instructions			er 1				er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
na diad	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		□ All
Medical	☐ AII	□ All			☐ All	AII			□ All	
Emergency Room Services All Inpatient Hospital Services (inc. MH/SUD)	V	✓								
All impatient nospital services (inc. Min/30D)										
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit				\$60.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient										
Services				\$60.00						
Imaging (CT/PET Scans, MRIs)	V	✓	49%	\$250.00						
Speech Therapy				\$30.00						
				\$30.00						
Occupational and Physical Therapy Preventive Care/Screening/Immunization	П	П								
Laboratory Outpatient and Professional Services	✓	✓								
X-rays and Diagnostic Imaging	V	V			_	H				
Skilled Nursing Facility	<u> </u>	<u> </u>								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<b>V</b>	V								
Outpotiont Surgery Physician / Surgical Society	V	<b>V</b>								
Outpatient Surgery Physician/Surgical Services  Drugs	□ All	□ All			□ All	□ All			□ All	□ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$120.00						
Options for Additional Benefit Design Limits:			Plan Description:	:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-FN_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004009	1-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?	_									
# Copays (1-10):										
Output										
Calculate  Status (Free Message)	Calculation Com-	i. d								
Status/Error Messages: Actuarial Value:	Calculation Successf 81.05%	ui.								
Metal Tier:	81.05% Gold									
The contract of the contract o	NOTE: One or more	services are not	subject to the ded	uctible and have no	copay. Any ser	vice with this co	st-sharing structure	is covered at	100% by the plan in	the deductible
Additional Notes:	range. NOTE: Office		-						, o by the plantin	300000000
, adicional recess	Ç		. 0	3 .,.	0-					
Calculation Time:	0.0508 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option			ered Network Op				
Apply Inpatient Copay per Day?		HSA/HRA Empl	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contrib	bution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?  Desired Metal Tier										
Desired Metal Her		r 1 Plan Benefit De	eian		Tio	· 2 Plan Benefit D	Dosign			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$1,500.00	\$0.00	Companied		medical	2.08	Companed			
Coinsurance (%, Insurer's Cost Share)		100.00%								
MOOP (\$)	\$6,5	00.00				•				
MOOP if Separate (\$)				<del></del>						
Click Here for Important Instructions		Tie					er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if		Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies onl	y after deductible
No. disal	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		□ All
Medical	☐ All	☐ All	000/	\$250.00	All				□ All	
Emergency Room Services All Inpatient Hospital Services (inc. MH/SUD)	V	V	89%	\$250.00						
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$25.00						
Specialist Visit				\$50.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$50.00						
Services				ψ50.00						
Imaging (CT/PET Scans, MRIs)	<b>V</b>	<u>v</u>								
Speech Therapy				\$25.00						
Occupational and Physical Therapy				\$25.00						
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	<u> </u>	<u> </u>								
X-rays and Diagnostic Imaging	V	<u> </u>								
Skilled Nursing Facility	V	✓								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	V								
Outpatient Surgery Physician/Surgical Services	V	v								
Drugs	☐ AII	□ All		<u> </u>	☐ All	□ All			□ All	☐ All
Generics				\$10.00		_				
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00 \$120.00						
Specialty Drugs (i.e. high-cost)  Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?	П	1	Name:	BH-FQ						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001004	2-01					
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):			Issuer HIOS ID:	41842						
Begin Primary Care Cost-Sharing After a Set Number of Visits?	П	1								
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of		1								
Copays?										
# Copays (1-10):		]								
Output Calculate										
Status/Error Messages:	Error: Result is ou	tside of [-4, +2] per	cent de minimis va	ariation.						
Actuarial Value:	83.41%									
Metal Tier:										
						vice with this co	st-sharing structure	is covered at	100% by the plan in	the deductible
Additional Notes:	range. NOTE: Off	ice-visit-specific co	st-sharing is applyi	ing to x-rays in offic	ce settings.					
Calculation Time:	0.0586 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Options			red Network O				
Apply Inpatient Copay per Day?		HSA/HRA Empl	oyer Contribution	i? □	Tiere	d Network Plan?	· 🗆			
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	oution Amount:		1st	Tier Utilization:	:			
Use Separate MOOP for Medical and Drug Spending?		Annual Contin	dation Amount.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Gold ▼			_						
	Tier	1 Plan Benefit De	sign		Tier	2 Plan Benefit I	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$1,500.00	\$0.00								
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$6,50	0.00								
MOOP if Separate (\$)										
Click Here for Important Instructions		Tie					ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if		Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible?
··	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☐ All	☐ All			All	All			☐ All	All
Emergency Room Services	v	✓	89%	\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$25.00						
Specialist Visit				\$50.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				750.00						
Services				\$50.00						
Imaging (CT/PET Scans, MRIs)	V	V	61%	\$250.00						
Speech Therapy			01/0	\$25.00						
Specifically										
Occupational and Physical Therapy				\$25.00						
Preventive Care/Screening/Immunization		П								
Laboratory Outpatient and Professional Services						_				
X-rays and Diagnostic Imaging	V	₹								Ö
Skilled Nursing Facility	<b>V</b>	<u>v</u>								
Skilled (Vd) Sing 1 activity										
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	V	39%	\$250.00						
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$120.00						
Options for Additional Benefit Design Limits:			Plan Description:	:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-FQ_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001004	2-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	tul.								
Actuarial Value:	78.74%									
Metal Tier:	Gold	_			_					
			•						100% by the plan in	
Additional Notes:				ing to x-rays in offic	ce settings. NOT	E: Service-speci	tic cost-sharing is a	pplying for sei	vice(s) with fac/prof	components,
	overriding outpatie	nt inputs for those	e service(s).							
Calculation Time:	0.0391 seconds									
Final 2019 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:	s	Tie	red Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiered	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		7 iiii dai comai			2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_	_					
		1 Plan Benefit De	1			2 Plan Benefit D				
Deductible (\$)	<b>Medical</b> \$1,500.00	<b>Drug</b> \$0.00	Combined		Medical	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)		00.00		-						
MOOP (\$)	20,30	0.00		-						
moor ii separate (y)			-				1			
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		6. 1.1
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	V	V	89%	\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$25.00						
Filling Care visit to freat arringary or filliess (exc. Freventive, and x-rays)				\$25.00	_					
Specialist Visit				\$50.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$50.00						
Services					l .					
Imaging (CT/PET Scans, MRIs)	V	V	61%	\$250.00						
Speech Therapy				\$25.00						
Occupational and Physical Therapy				\$25.00						
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	<u></u>	v								
X-rays and Diagnostic Imaging	_ V	✓								
Skilled Nursing Facility	✓	✓								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	V				_				
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	All	□ All			□ All				All	□ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$120.00						
Options for Additional Benefit Design Limits:		•	Plan Description	:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-FQ_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001004	2-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):	_									
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays? # Copays (1-10):										
Output										
Calculate										
	Error: Result is out	side of [-4, +2] nei	cent de minimis va	riation.						
	82.53%									
Metal Tier:										
	NOTE: One or mor	e services are not	subject to the ded	uctible and have no	copay. Any ser	vice with this co	st-sharing structure	is covered at	100% by the plan in	the deductible
	range. NOTE: Office						•		•	
Calculation Time:	0.0469 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:	5	Tie	red Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiered	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		7 miliaar correin			2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		451 5 615			_					
		1 Plan Benefit De	1	+		2 Plan Benefit D				
Deductible (\$)	\$1,500.00	<b>Drug</b> \$0.00	Combined		Medical	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)		00.00		•						
MOOP if Separate (\$)	\$0,50	0.00		-						
			•							
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
Town of Donnella	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Camari annlias anh	
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	/ arter deductible
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	Ŋ	V	89%	\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)	<b>&gt;</b>	✓								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$25.00						
					_					_
Specialist Visit				\$50.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$50.00						
Services				-	l .					
Imaging (CT/PET Scans, MRIs)	<b>&gt;</b> [	V		ć2F 00						
Speech Therapy				\$25.00						
Occupational and Physical Therapy				\$25.00						
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	) \	<u> </u>								
X-rays and Diagnostic Imaging	V	<u> </u>								
Skilled Nursing Facility	V	V								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	V								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			□ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$120.00						
Options for Additional Benefit Design Limits:		Ì	Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-FR						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004004	5-01					
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):	П		Issuer HIOS ID:	41842						
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of	П									
Copays?										
# Copays (1-10):										
Output										
Calculate										
	Error: Result is out	side of [-4, +2] per	rcent de minimis va	riation.						
	83.41%									
Metal Tier:										
						vice with this co	st-sharing structure	is covered at	100% by the plan in	the deductible
Additional Notes:	range. NOTE: Offi	ce-visit-specific co	st-sharing is applyi	ng to x-rays in offic	ce settings.					
Calculation Time:	0.0586 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Options			ered Network O				
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:		1s	t Tier Utilization:	:			
Use Separate MOOP for Medical and Drug Spending?		Annual Contin	bation Amount.		2nd	d Tier Utilization:	:			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_	<b>-</b>					
		1 Plan Benefit De	1			2 Plan Benefit I				
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$1,500.00	\$0.00								
Coinsurance (%, Insurer's Cost Share)		100.00%		_						
MOOP (\$)	\$6,50	0.00								
MOOP if Separate (\$)							l			
						_	_		T = .	
Click Here for Important Instructions			er 1	,			ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
Medical	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	□ All	☐ All
Emergency Room Services	Ŭ All	✓ All	89%	\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)	☑	✓	03/0	\$230.00						
All Impatient Hospital Services (inc. Min/300)										
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$25.00						
Specialist Visit				\$50.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$30.00						
Services				\$50.00						
Imaging (CT/PET Scans, MRIs)	✓	V	61%	\$250.00						
Speech Therapy			0270	\$25.00						
Occupational and Physical Therapy				\$25.00						
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	<u> </u>	V								
X-rays and Diagnostic Imaging	_ _									
Skilled Nursing Facility	✓	✓								
				4	_	_				_
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓	39%	\$250.00						
Outpatient Surgery Physician/Surgical Services	V	✓								
Drugs	☐ AII	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$120.00						
Options for Additional Benefit Design Limits:			Plan Description:	:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-FR_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004004	5-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output Calculate										
Status/Error Messages:	Calculation Success	ful								
Actuarial Value:	78.74%	iui.								
Metal Tier:	78.74% Gold									
metal fiel.		services are not	subject to the dod	uctible and have no	n conav. Any co-	wice with this co	ct-charing etructur	e is covered a	100% by the plan in	the deductible
Additional Nation			-				-		vice(s) with fac/prof	
Additional Notes:	overriding outpatie			III LU A-I dys III UIII	ce securigs. NO	L. Jei vice-speci	inc cost-silatilig is a	ippiying IOI Se	vice(s) with rat/prof	components,
		it inputs for those	c scivice(s).							
Calculation Time:	0.0352 seconds									
Final 2019 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option			ered Network Op				
Apply Inpatient Copay per Day?		HSA/HRA Empl	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contrib	bution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?  Desired Metal Tier	Gold ▼									
Desired Metal Her		r 1 Plan Benefit De	sian		Tio	· 2 Plan Benefit D	Dosign			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$1,500.00	\$0.00	Compilied		medical	2.08	Companed			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$6,5	00.00				•				
MOOP if Separate (\$)				<del></del>						
·					1					
Click Here for Important Instructions		Tie					er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies onl	y after deductible
No. disal	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		□ All
Medical	☐ AII	☐ All	000/	\$250.00					□ All	
Emergency Room Services All Inpatient Hospital Services (inc. MH/SUD)	V	V	89%	\$250.00						
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$25.00						
Specialist Visit				\$50.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$50.00						
Services										
Imaging (CT/PET Scans, MRIs)	<b>V</b>	<u>v</u>	61%	\$250.00						
Speech Therapy				\$25.00						
Occupational and Physical Therapy				\$25.00						
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	<u> </u>	<u> </u>								
X-rays and Diagnostic Imaging	V	<u> </u>								
Skilled Nursing Facility	V	✓								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	V								
Outpatient Surgery Physician/Surgical Services	V	v								
Drugs	□ AII	□ All		<u> </u>	☐ All	□ All			□ All	☐ All
Generics				\$10.00		_				
Preferred Brand Drugs				\$40.00						_
Non-Preferred Brand Drugs				\$75.00 \$120.00						
Specialty Drugs (i.e. high-cost)  Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?	П	1	Name:	BH-FR POST						
Specialty Rx Coinsurance Maximum:	_		Plan HIOS ID:	41842DC004004	5-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):  Begin Primary Care Cost-Sharing After a Set Number of Visits?		+								
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of		1								
Copays?										
# Copays (1-10):										
Output Calculate										
Status/Error Messages:	Frror: Result is out	tside of [-4, +2] per	rent de minimis va	ariation						
Actuarial Value:	82.53%	ac or [ 4, +2] per	Contrac minimins Ve							
Metal Tier:										
	NOTE: One or mo	re services are not :	subject to the ded	uctible and have no	copay. Any sei	vice with this co	st-sharing structure	is covered at	100% by the plan in	the deductible
Additional Notes:		ice-visit-specific co					-			
Calculation Time:	0.043 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:	s	Tie	ered Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		7 mildar correin	oution, and and		2nd	d Tier Utilization:	:			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		4 Dl D 64 D.	-1		T1	2 Dl D 6'4 I	D!			
	Medical	r 1 Plan Benefit De	Combined	-	Medical	2 Plan Benefit I	Combined			
Deductible (\$)		<b>Drug</b> \$250.00	Combined		iviedicai	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)		100.00%								
MOOP (\$)		00.00								
MOOP if Separate (\$)		1		-						
moor in separate (y)			-				•			
Click Here for Important Instructions		Tie	er 1			Т	ier 2		Tier 1	Tier 2
- (- (-	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	6	
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies on	y after deductible?
Medical	☐ AII	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	V			\$500.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	V			\$500.00					V	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
					_					_
Specialist Visit	V			\$60.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00						
Services			76%	\$150.00						
Imaging (CT/PET Scans, MRIs) Speech Therapy			76%	\$30.00						
Speculinerapy				\$30.00						
Occupational and Physical Therapy				\$30.00						
Preventive Care/Screening/Immunization		П								
Laboratory Outpatient and Professional Services	V	✓								
X-rays and Diagnostic Imaging	<u> </u>	✓								
Skilled Nursing Facility	✓			\$500.00					✓	
			500/	4450.00		П				П
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓	63%	\$150.00		ш				
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ AII	☐ AII			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	<b>V</b>			\$40.00					<u> </u>	
Non-Preferred Brand Drugs	Ŋ			\$75.00					<u> </u>	
Specialty Drugs (i.e. high-cost)	✓		Dian Description	\$120.00					✓	
Options for Additional Benefit Design Limits:  Set a Maximum on Specialty Rx Coinsurance Payments?		1	Plan Description Name:	: BH-FS						
Specialty Rx Coinsurance Payments:  Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001008	<b>4</b> -01					
Set a Maximum Number of Days for Charging an IP Copay?	П	-	Issuer HIOS ID:	41842	4-01					
# Days (1-10):				11012						
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of		1								
Copays?										
# Copays (1-10):		]								
Output										
Calculate										
Status/Error Messages:		tside of [-4, +2] per	cent de minimis va	ariation.						
Actuarial Value:	75.96%									
Metal Tier:	NOTE: One or or	ro condicos ses = - +	cubioct to the d1	uctible and barre	consu Amir	avica with this	et charing struct	ie covered -+	100% by the ale: !:	the deductible
Additional Nation			-				-		100% by the plan in vice(s) with fac/pro	
Additional Notes:		ent inputs for those		ing to x-rays iii OIIIC	c securigs. NU	L. Jei vice-speci	inc cost-silatilig is d	PPIYING TOT SET	vice(s) with rat/pro	components,
- L L :: -	= :	cpats for those	C 3C. VICC(3).							
Calculation Time:	0.0469 seconds									
Final 2019 AV Calculator										

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:	s	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:		1st	t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Annual Contin	bation Amount.		2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				=						
		Plan Benefit De	1			2 Plan Benefit I				
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,000.00	\$250.00								
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%		-						
MOOP (\$)	\$6,000	.00								
MOOP if Separate (\$)							1			
Click Here for Important Instructions		Tia	er 1			Ti	er 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	y after deductible
Medical	All	□ All	uniciciit	эсрание	☐ All	All	4	<b>Беринис</b>	☐ All	☐ All
Emergency Room Services				\$500.00					<u> </u>	
All Inpatient Hospital Services (inc. MH/SUD)	V			\$500.00					v	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit	V			\$60.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient										
Services				\$60.00						
Imaging (CT/PET Scans, MRIs)	<b>V</b>	<b>V</b>	76%	\$150.00						
Speech Therapy				\$30.00						
				\$30.00						
Occupational and Physical Therapy				\$30.00						
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	V	v								
X-rays and Diagnostic Imaging	∨	✓								
Skilled Nursing Facility	V			\$500.00					₹.	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	□ All	☐ All			□ All	□ All			□ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	<b>V</b>			\$40.00					V	
Non-Preferred Brand Drugs	✓			\$75.00					V	
Specialty Drugs (i.e. high-cost)	V			\$120.00					V	
Options for Additional Benefit Design Limits:			Plan Description	:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-FS						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001008	4-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output Calculate										
	Calculation Cus									
Status/Error Messages:	Calculation Successf 77.96%	uı.								
Actuarial Value: Metal Tier:	77.96% Gold									
Wicker rich.	NOTE: One or more	services are not	subject to the ded	uctible and have no	CODAY Anyses	wice with this co	ct-charing ctructure	s is covered at	100% by the plan in	the deductible
Additional Notes:	range. NOTE: Office					**************************************	or onaring or uctuit	covereu di	20070 by the plantill	c acadelible
Additional Notes.	.abc. NOTE. Office	specific co	os sharing is applyi		oc octango.					
Coloriation Times	0.0025									
Calculation Time:	0.0625 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Tie	red Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Empl	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:		1st	Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Allitual Colletti	bution Amount.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Gold ▼			_						
	Tier	1 Plan Benefit De	sign		Tier	2 Plan Benefit [	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,000.00	\$250.00								
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$6,00	00.00								
MOOP if Separate (\$)							<u> </u>			
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	copay applies only	
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	V			\$500.00					✓	
All Inpatient Hospital Services (inc. MH/SUD)	V	✓								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit	V			\$60.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient					_					
Services				\$60.00						
Imaging (CT/PET Scans, MRIs)	✓	V	76%	\$150.00						
Speech Therapy				\$30.00						
Occupational and Physical Therapy				\$30.00						
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	V									
X-rays and Diagnostic Imaging	V	<b>V</b>								
Skilled Nursing Facility	✓			\$500.00					✓	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	✓	63%	\$150.00						
Outpatient Surgery Physician/Surgical Services	✓	✓								
Drugs	□ All	□ All			□ All	□ All			□All	All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00	_				☑	
Non-Preferred Brand Drugs	V	- i		\$75.00	_				V	
Specialty Drugs (i.e. high-cost)	V			\$120.00					<b>V</b>	
Options for Additional Benefit Design Limits:			Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?	П		Name:	BH-FS						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001008	4-01					
Set a Maximum Number of Days for Charging an IP Copay?	П		Issuer HIOS ID:	41842	. 01					
# Days (1-10):				12012						
Begin Primary Care Cost-Sharing After a Set Number of Visits?	П									
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Succes	sful.								
Actuarial Value:	76.10%									
Metal Tier:	Gold									
			-				_		100% by the plan in	
Additional Notes:	range. NOTE: Office overriding outpaties			ng to x-rays in offic	ce settings. NOT	E: Service-speci	fic cost-sharing is a	pplying for se	rvice(s) with fac/prof	components,
Calculation Time:	0.0547 seconds									
Final 2019 AV Calculator	o.ob47 seconds									
===== ========										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Annual Contin	oution Amount.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_						
		L Plan Benefit De				2 Plan Benefit D				
- L .: L .: A	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,000.00	\$250.00								
Coinsurance (%, Insurer's Cost Share) MOOP (\$)	100.00%	100.00%		-		ļ				
MOOP (\$)  MOOP if Separate (\$)	\$6,000	1.00		_						
WOOF II Separate (3)							l			
Click Here for Important Instructions		Tie	er 1			Tie	er 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible
Medical	☐ All	☐ All		· ·	All	☐ All		·	☐ All	☐ All
Emergency Room Services	>			\$500.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	<b>V</b>	✓								
				¢20.00	_	_				_
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit	V			\$60.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00	П	_				_
Services					_					
Imaging (CT/PET Scans, MRIs)	V	V	76%	\$150.00						
Speech Therapy				\$30.00						
Occupational and Physical Therapy				\$30.00						
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	<u> </u>	✓								
X-rays and Diagnostic Imaging	V	V				H				
Skilled Nursing Facility	· ·			\$500.00					<u> </u>	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		V								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00					<u> </u>	
Non-Preferred Brand Drugs	N [			\$75.00					Ŋ.	
Specialty Drugs (i.e. high-cost)	~			\$120.00					~	
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name: Plan HIOS ID:	BH-FS	4.04					
Specialty Rx Coinsurance Maximum:  Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842DC0010084 41842	4-01					
# Days (1-10):			issuer HIOS ID:	41842						
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
. 9	Calculation Successi	ul.								
	78.19%									
Metal Tier:	Gold									
	NOTE: One or more					rvice with this co	st-sharing structure	is covered at	100% by the plan in	the deductible
Additional Notes:	range. NOTE: Office	e-visit-specific co	st-sharing is applyi	ng to x-rays in offic	e settings.					
Calculation Time:	0.0508 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:	s	Tie	ered Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		7 miliaar corners	oution, and and		2nd	d Tier Utilization:	:			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		4 Dl D ft D.	-1	_	T1	2 Dl D 6'4 I	Da eterr			
	Medical	r 1 Plan Benefit De	Combined	-	Medical	2 Plan Benefit I	Combined			
Deductible (\$)		<b>Drug</b> \$250.00	Combined		iviedicai	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)		00.00								
MOOP if Separate (\$)	\$0,0	00.00		-						
			•				•			
Click Here for Important Instructions		Tie	er 1			T	ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Conay applies onl	y after deductible?
туре от венени	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies offi	y arter deductible:
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	<b>V</b>			\$500.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	V			\$500.00					V	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
					_					_
Specialist Visit	V			\$60.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient Services				\$60.00						
Imaging (CT/PET Scans, MRIs)	V	<b>V</b>	53%	\$300.00						
Speech Therapy			3370	\$30.00						
Occupational and Physical Therapy				\$30.00						
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	V	✓								
X-rays and Diagnostic Imaging	V	✓								
Skilled Nursing Facility	V			\$500.00					V	
Outpatient Facility Foo (o.g., Ambulaton; Surgen; Contor)	V	V	27%	\$300.00		П				П
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)			27/0	\$300.00		_				_
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00		_			2	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	•		Plan Description	\$120.00	L	Ш			V	Ш
Options for Additional Benefit Design Limits:  Set a Maximum on Specialty Rx Coinsurance Payments?		1	Name:	BH-FS_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001008	4-01					
Set a Maximum Number of Days for Charging an IP Copay?	П	1	Issuer HIOS ID:	41842	- 01					
# Days (1-10):	_									
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:		tside of [-4, +2] per	cent de minimis va	ariation.						
Actuarial Value:	74.63%									
Metal Tier:	NOTE: One or or	ro condicos see e - t	cubioce ec ebo d	uctible and bace	consu Amir-	avica with this	et charing struct	ie covered -+	100% by the ale: !:	the deductible
Additional Nation			-				-		100% by the plan in vice(s) with fac/pro	
Additional Notes:		ent inputs for those		ing to x-rays in Offic	e settings. NO	L. Jei vice-speci	inc cost-snaring is a	philing ioi sei	vice(s) with rac/pro	components,
Colordation Times	= :	cpats for those	C 3C. VICC(3).							
Calculation Time:	0.0625 seconds									
Final 2019 AV Calculator										

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:	s	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:		1s	t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Annual Contin	bation Amount.		2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_						
		Plan Benefit De				2 Plan Benefit D				
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,000.00	\$250.00								
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$6,000	.00								
MOOP if Separate (\$)							l			
Clieb Hore for Important Instructions		T:	er 1			т:	er 2		Tier 1	Tier 2
Click Here for Important Instructions	Cubbanka			C 16	Cubbanka			C 'f	Her 1	Her 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
BA - di d	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		□ All
Medical	□ All	☐ All		4500.00	_				□ All	
Emergency Room Services	V			\$500.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	V			\$500.00					V	Ш
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
	✓								✓	
Specialist Visit	V			\$60.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00						
Services	✓	_	F30/	ć200.00						
Imaging (CT/PET Scans, MRIs)		~~~~~~~	53%	\$300.00	• • • • • • • • • • • • • • • • • • • •					
Speech Therapy				\$30.00						
Occupational and Physical Therapy				\$30.00						
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	✓	✓								
X-rays and Diagnostic Imaging	V	<b>V</b>								
Skilled Nursing Facility	<b>▽</b>			\$500.00					✓	
Skilled Ndr3ing Lacinty				3300.00						
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓								
Outpatient Surgery Physician/Surgical Services	✓	V								
Drugs	□ All	□ All			□ All	□ All			□ All	□ All
Generics				\$10.00						
Preferred Brand Drugs	<b>☑</b>			\$40.00					v	
Non-Preferred Brand Drugs				\$75.00					<u> </u>	
Specialty Drugs (i.e. high-cost)	✓			\$120.00		П			✓	
Options for Additional Benefit Design Limits:			Plan Description						_	
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-FS POST						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001008	4-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output	_									
Calculate										
Status/Error Messages:	Calculation Successf	ul.								
	77.55%									
Metal Tier:	Gold									
	NOTE: One or more	services are not	subject to the ded	uctible and have no	copay. Any sei	rvice with this co	st-sharing structure	e is covered at	100% by the plan in	the deductible
Additional Notes:	range. NOTE: Office	-visit-specific co	st-sharing is applyi	ng to x-rays in offic	e settings.					
Calculation Time:	0.0547 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:	s	Tie	ered Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			t Tier Utilization				
Use Separate MOOP for Medical and Drug Spending?		7 mildar comen	oution, and and		2nd	d Tier Utilization	:			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		4 Dl D 64 D.	-1		T1	2 Dl D 6'4 l	Davies.			
	Medical	r 1 Plan Benefit De	Combined	-	Medical	2 Plan Benefit	Combined			
Deductible (\$)		<b>Drug</b> \$250.00	Combined		iviedicai	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)		100.00%								
MOOP (\$)		00.00								
MOOP if Separate (\$)		00.00		-						
			•				-			
Click Here for Important Instructions		Tie	er 1			Т	ier 2		Tier 1	Tier 2
T	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Canau annliae anl	
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies on	y after deductible?
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	V			\$500.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	V	✓								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
					_					_
Specialist Visit	V			\$60.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00						
Services Imaging (CT/PET Scans, MRIs)			53%	\$300.00						
Speech Therapy			33/6	\$30.00		_				
эреситиетару										
Occupational and Physical Therapy				\$30.00						
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	V	<b>V</b>								
X-rays and Diagnostic Imaging	_ V									
Skilled Nursing Facility	✓			\$500.00					✓	
	V	V	27%	¢200.00		П				П
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)			2/70	\$300.00		_				_
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ AII	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	<u> </u>			\$40.00					_	
Non-Preferred Brand Drugs	Ø			\$75.00					V	
Specialty Drugs (i.e. high-cost)	✓		Plan Description	\$120.00	L				V	Ш
Options for Additional Benefit Design Limits:  Set a Maximum on Specialty Rx Coinsurance Payments?		1	Name:	BH-FS_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001008	4-01					
Set a Maximum Number of Days for Charging an IP Copay?	П	1	Issuer HIOS ID:	41842	- 01					
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of		]								
Copays?										
# Copays (1-10):		]								
Output										
Calculate	h									
Status/Error Messages:		tside of [-4, +2] per	cent de minimis va	ariation.						
Actuarial Value:	74.72%									
Metal Tier:	NOTE: One or	re services are set	subject to the ded	uctible and have an	CODSV ANV SS	nuice with this as	set-charing etruct	is covered at	100% by the plan in	the deductible
Additional Nation			-				-		vice(s) with fac/pro	
Additional Notes:		ent inputs for those		ing to x-rays in Offic	c settings. NO	i L. Dei vice-speci	inc cost-snaring is a	Philing Ioi sei	vice(s) with rac/pro	components,
Colordation Times	= :									
Calculation Time: Final 2019 AV Calculator	0.0469 seconds									
riilai 2013 AV CaiCulator										

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:	s	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	ibution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Annual Contri	battori Amount.		2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_						
		Plan Benefit De	1			2 Plan Benefit I				
	Medical	Drug	Combined	_	Medical	Drug	Combined			
Deductible (\$)	\$2,000.00	\$250.00								
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%		-						
MOOP (\$)	\$6,000	.00								
MOOP if Separate (\$)							1			
Click Here for Important Instructions		Tia	er 1			Ti	ier 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies onl	y after deductible
Medical	All	□ All	uniciciit	Separate	All	All	uniciciit	<b>Беринис</b>	☐ All	☐ All
Emergency Room Services				\$500.00					<u> </u>	
All Inpatient Hospital Services (inc. MH/SUD)	V	✓								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit	<b>V</b>			\$60.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient										
Services				\$60.00						
Imaging (CT/PET Scans, MRIs)	V	<b>V</b>	53%	\$300.00						
Speech Therapy				\$30.00						
				\$30.00						
Occupational and Physical Therapy				\$30.00						
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	V	v								
X-rays and Diagnostic Imaging	<b>V</b>	✓								
Skilled Nursing Facility	>			\$500.00					V	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	<b>V</b>								
Outpoblight Current Physician / Curring I Continue	V	<b>V</b>								
Outpatient Surgery Physician/Surgical Services  Drugs	□ All	□ All			□ All	□ All			□ All	□ All
Generics				\$10.00						
Preferred Brand Drugs	<u> </u>			\$40.00	_				V	
Non-Preferred Brand Drugs	V			\$75.00	_				V	
Specialty Drugs (i.e. high-cost)	<b>V</b>			\$120.00					V	
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-FS_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001008	4-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate Status (Free Message)	Calculation Cus f	I								
Status/Error Messages:	Calculation Successf 77.78%	ui.								
Actuarial Value: Metal Tier:	77.78% Gold									
Wicker rich.	NOTE: One or more	services are not	subject to the ded	uctible and have no	n conav. Anv se	wice with this co	ct-charing ctructure	s is covered at	100% by the plan in	the deductible
Additional Notes:	range. NOTE: Office					**************************************	or manning structure	covereu di	20070 by the platfill	acadelibie
Additional Notes.	.agc. NOTE. Office	specific co	oc sharing is applyi	x 14y3 111 01111	ce settings.					
Coloriation Times	0.0702									
Calculation Time:	0.0703 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Tie	ered Network Op	tion			
Apply Inpatient Copay per Day?		HSA/HRA Empl	oyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contrib	oution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		1 Plan Benefit De	alau.	_	Tion	· 2 Plan Benefit D	and an			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,500.00	\$250.00	Combined		ivieuicai	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%								
MOOP (\$)	\$7,90			Ī		1				
MOOP if Separate (\$)				-						
			_				•			
Click Here for Important Instructions		Tie	r 1			Tie	er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☐ All	☐ All			All	☐ All			☐ All	☐ All
Emergency Room Services	<b>V</b>	<u> </u>								
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$50.00						
				A.o	_					
Specialist Visit  Mental/Behavioral Health and Substance Use Disorder Outpatient	Ш			\$100.00						
Services				\$100.00						
Imaging (CT/PET Scans, MRIs)		V	54%	\$299.97						П
Speech Therapy				\$50.00						
Occupational and Physical Therapy		Ш		\$50.00						
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	V	v								
X-rays and Diagnostic Imaging	V	✓								
Skilled Nursing Facility	✓	✓								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		V	29%	\$212.45	-					
Outpatient Surgery Physician/Surgical Services	V	✓								
Drugs	☐ AII	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	<u> </u>			\$40.00					<u> </u>	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	✓		Dlan Description	\$120.00					✓	
Options for Additional Benefit Design Limits:  Set a Maximum on Specialty Rx Coinsurance Payments?			Plan Description: Name:	: BH-FT						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC0010080	0-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842	0 01					
# Days (1-10):	_									
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate Status / France Massacces	Calculation Com	£1								
Status/Error Messages: Actuarial Value:	Calculation Success 70.12%	iui.								
Metal Tier:	70.12% Silver									
rectal fier.		services are not	subject to the ded	uctible and have no	copay. Any see	vice with this co	st-sharing structure	is covered at	100% by the plan in	the deductible
Additional Notes:							-		vice(s) with fac/prof	
, wantonia resess	overriding outpatie			3 .,.	0		3.00		, / [	
Calculation Time:	0.0391 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	5	Tie	ered Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:		1st	Tier Utilization	:			
Use Separate MOOP for Medical and Drug Spending?		Annual Contin	button Amount.		2nd	Tier Utilization	:			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_						
		1 Plan Benefit De	1			2 Plan Benefit				
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,500.00	\$250.00								
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%								
MOOP (\$)		0.00								
MOOP if Separate (\$)										
		_				_				
Click Here for Important Instructions		Tie					ier 2		Tier 1	Tier 2
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies onl	y after deductible
Medical	□ All	□ All	amerent	separate	All	All	different	separate	☐ All	□ All
	✓ All	✓ All								All
Emergency Room Services	V									
All Inpatient Hospital Services (inc. MH/SUD)		<b>V</b>								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$50.00						
Specialist Visit				\$100.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$100.00						
Services				\$100.00						
Imaging (CT/PET Scans, MRIs)		V	54%	\$299.97						
Speech Therapy			34/0	\$50.00						
эреесптиетару				\$30.00						
Occupational and Dhysical Thoras				\$50.00						
Occupational and Physical Therapy Preventive Care/Screening/Immunization										
						H				
Laboratory Outpatient and Professional Services	<ul><li>✓</li><li>✓</li></ul>	V								
X-rays and Diagnostic Imaging		<u> </u>			H					
Skilled Nursing Facility	V									<u> </u>
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		✓								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	□ All	□ All			□ All	□ All			□ All	□ All
				\$10.00						Aii
Generics Preferred Brand Drugs	V			\$40.00					V	= =
	V			\$75.00					V	
Non-Preferred Brand Drugs Specialty Drugs (i.e. high-cost)	☑			\$120.00					V	
	•		Dian Description		ш				<u> </u>	
Options for Additional Benefit Design Limits:  Set a Maximum on Specialty Rx Coinsurance Payments?			Plan Description: Name:	BH-FT						
Specialty Rx Coinsurance Payments?  Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001008	0.01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842	0-01					
# Days (1-10):			issuer HIOS ID:	41842						
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	ful								
Actuarial Value:	71.88%	iui.								
Metal Tier:	71.88% Silver									
Mictal fiel.	NOTE: One or more	services are not	subject to the dod	uctible and have no	a consu. Any cor	wice with this co	oct-charing ctructur	is covered at	100% by the plan in	the deductible
Additional News	range. NOTE: Office						-			
Additional Notes:	overriding outpatier			ing to x-rays in Offic	ce secungs. NOI	L. Jei vice-speci	inic cost-snaring is a	ppryring ror ser	vice(s) with rat/pro	components,
		it iriputs for triosi	e sei vice(S).							
Calculation Time:	0.043 seconds									
Final 2019 AV Calculator										

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?	_	71111001 0011011	Dation 7 unio ant.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				=						
		Plan Benefit De	1			2 Plan Benefit D				
- 1 44	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,500.00	\$250.00								
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%		-		L				
MOOP (\$)	\$7,900	.00								
MOOP if Separate (\$)							l			
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	/ after deductib
Medical	All	□ All	uniciciit	эсрагасс	□ All	□ All	umerem	зерание	☐ All	☐ All
Emergency Room Services		<u> </u>								
All Inpatient Hospital Services (inc. MH/SUD)	> >	✓								
***************************************										
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$50.00						
Specialist Visit				\$100.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient										
Services				\$100.00						
Imaging (CT/PET Scans, MRIs)		✓	54%	\$299.97						
Speech Therapy				\$50.00						
				\$50.00						
Occupational and Physical Therapy				\$50.00						
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	V	v								
X-rays and Diagnostic Imaging	V	V								
Skilled Nursing Facility	V	<b>V</b>								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	V								
Outpatient Surgery Physician/Surgical Services	V	✓								
Drugs	□ All	☐ All			☐ All	☐ All			□ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	•			\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	V			\$120.00					✓	
Options for Additional Benefit Design Limits:			Plan Description:	•						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-FT						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001008	0-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):	_									
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output Calculate										
Status/Error Messages:	Calculation Successf	ul.								
Actuarial Value:	71.09%	ui.								
Metal Tier:	71.09% Silver									
metal nen	NOTE: One or more	services are not	subject to the ded	uctible and have no	CODAY ADVISE	vice with this co	st-sharing structure	is covered at	100% by the plan in	the deductible
Additional Notes:	range. NOTE: Office					**********************************	or onaring orracture	covereu at	20070 by the plantill	acaactible
Additional Notes.	.agc. NOTE. Office	specific co	os sharing is applyi		ce settings.					
Calculation Times	0.0500									
Calculation Time:	0.0508 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:	s	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		. Plan Benefit De	scian		Tion	· 2 Plan Benefit D	Nosian			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,500.00	\$250.00	Combined		ivieuicai	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%								
MOOP (\$)	\$7,900					1				
MOOP if Separate (\$)				-			·			
Click Here for Important Instructions			er 1				er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
Medical	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	☐ All	□ All
Emergency Room Services	☑ All	✓ All				AII				
All Inpatient Hospital Services (inc. MH/SUD)	V	<b>V</b>								
				*						
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$50.00						
Specialist Visit				\$100.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$100.00		П				
Services					_	_				
Imaging (CT/PET Scans, MRIs)		V	54%	\$299.97						
Speech Therapy				\$50.00						
Occupational and Physical Therapy				\$50.00						
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	V	v								
X-rays and Diagnostic Imaging	V	V								
Skilled Nursing Facility	V	V								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓								
Outpatient Surgery Physician/Surgical Services	v	V								
Drugs	☐ AII	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	<b>V</b>			\$75.00					V	
Specialty Drugs (i.e. high-cost)	✓			\$120.00					✓	
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?  Specialty Rx Coinsurance Maximum:			Name: Plan HIOS ID:	BH-FT 41842DC001008	0.01					
Set a Maximum Number of Days for Charging an IP Copay?	П		Issuer HIOS ID:	41842	0-01					
# Days (1-10):			issuel filos ib.	41042						
Begin Primary Care Cost-Sharing After a Set Number of Visits?	П									
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output Calculate										
Status/Error Messages:	Calculation Successf	ul.								
Actuarial Value:	71.09%									
Metal Tier:	Silver									
	NOTE: One or more	services are not	subject to the ded	uctible and have no	copay. Any ser	vice with this co	st-sharing structure	is covered at	100% by the plan in	the deductible
Additional Notes:	range. NOTE: Office	-visit-specific co	st-sharing is applyi	ng to x-rays in offic	ce settings.					
Calculation Time:	0.0586 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	5	Tie	ered Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:		1st	Tier Utilization				
Use Separate MOOP for Medical and Drug Spending?		7 ii ii idai Contin	bacion / uno aric.		2nd	Tier Utilization				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_						
		1 Plan Benefit De	1	_		2 Plan Benefit				
Destructible (A)	Medical	Drug	Combined	-	Medical	Drug	Combined			
Deductible (\$)	\$2,500.00 70.00%	\$250.00 100.00%								
Coinsurance (%, Insurer's Cost Share) MOOP (\$)				-		ļ				
MOOP (\$)  MOOP if Separate (\$)		0.00		-						
WOOF II Separate (3)							1			
Click Here for Important Instructions		Tie	er 1			т	ier 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	y after deductible
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	~	<b>V</b>								
All Inpatient Hospital Services (inc. MH/SUD)	✓	✓								Ī
				ć=0.00	_	_			-	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$50.00						
Specialist Visit				\$100.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$100.00						
Services				\$100.00	_					_
Imaging (CT/PET Scans, MRIs)	V	V								
Speech Therapy				\$50.00						
				\$50.00						
Occupational and Physical Therapy				,						
Preventive Care/Screening/Immunization									_	_
Laboratory Outpatient and Professional Services	V	V								
X-rays and Diagnostic Imaging	V	<b>V</b>								
Skilled Nursing Facility	V	<u> </u>								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓			\$300.00					✓	
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	□ All	□ All			□ All	□ All			□ All	□ All
Generics				\$10.00					0	
Preferred Brand Drugs	☑			\$40.00					✓	
Non-Preferred Brand Drugs				\$75.00					_ ✓	
Specialty Drugs (i.e. high-cost)	<b>V</b>			\$120.00					V	
Options for Additional Benefit Design Limits:	•		Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-FT_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC0010080	0-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays? # Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	ful.								
Actuarial Value:	69.53%	-								
Metal Tier:	Silver									
	NOTE: One or more	services are not	subject to the dedu	uctible and have no	copay. Any ser	vice with this co	st-sharing structure	e is covered at	100% by the plan in	the deductible
Additional Notes:	range. NOTE: Office	e-visit-specific co	st-sharing is applyi	ng to x-rays in offic	e settings. NOT	E: Service-speci	fic cost-sharing is a	pplying for ser	rvice(s) with fac/pro	components,
	overriding outpaties	nt inputs for those	e service(s).							
Calculation Time:	0.0312 seconds									
Final 2019 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:	s	Tie	ered Network Op	tion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		I Plan Benefit De	alan.	_	Tion	2 Plan Benefit D	and an			
	Medical	Drug	Combined	-	Medical	Drug	Combined			
Deductible (\$)	\$2,500.00	\$250.00	Combined		ivieuicai	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%								
MOOP (\$)	\$7,900			<b>T</b>		1				
MOOP if Separate (\$)				-						
			-			•				
Click Here for Important Instructions		Tie	er 1			Tie	er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductib
·	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	□ All  ✓	☐ All			☐ All	☐ All			□ All	All
Emergency Room Services	V	<b>V</b>								
All Inpatient Hospital Services (inc. MH/SUD)		V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$50.00						
Specialist Visit				\$100.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient										
Services				\$100.00						
Imaging (CT/PET Scans, MRIs)	V	V								
Speech Therapy				\$50.00						
Occupational and Physical Therapy				\$50.00						
Preventive Care/Screening/Immunization	П									
Laboratory Outpatient and Professional Services	<u> </u>	v								
X-rays and Diagnostic Imaging	☑	V								
Skilled Nursing Facility	V	V								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓								
Outpatient Surgery Physician/Surgical Services	☑	V								
Drugs	□ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00					✓	
Non-Preferred Brand Drugs	V			\$75.00					V	_
Specialty Drugs (i.e. high-cost)	~			\$120.00					~	
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-FT_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001008	0-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):  Begin Primary Care Cost-Sharing After a Set Number of Visits?	_									
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of	П									
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	ful.								
Actuarial Value:	71.07%									
Metal Tier:	Silver		auhiank ka kha 200	I		nina mistrator			1000/	ala a da de cattal
A Little Control of the Control of t						vice with this cos	structure	is covered at	100% by the plan in t	trie deductible
Additional Notes:	range. NOTE: Office	=-visit-specific co	isc-sitating is applyt	ing to x-rays in OTTIC	e serriigs.					
Calculation Times	0.0204									
Calculation Time:	0.0391 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?	✓		HSA/HRA Options	s	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		7 ii ii dan Conten			2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier					_					
		r 1 Plan Benefit De	1	-		2 Plan Benefit D				
Deductible (\$)	Medical	Drug	\$2,600.00		Medical	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)			100.00%							
MOOP (\$)			\$6,700.00	+						
MOOP if Separate (\$)			\$0,700.00	→			<del>                                     </del>			
			•			-	1			
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
Towns of Description	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Canau annliae anh	
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	arter deductible
Medical	<b>✓</b> All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	V			\$150.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	V			\$500.00					V	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<b>V</b>			\$25.00					✓	
Specialist Visit	V			\$50.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient	✓			\$50.00					✓	
Services					_					
Imaging (CT/PET Scans, MRIs)	V	<u>v</u>		405.00						
Speech Therapy	V			\$25.00					V	
Occupational and Bluminal Thomas	✓			\$25.00					✓	
Occupational and Physical Therapy Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services		✓								
X-rays and Diagnostic Imaging	V	V				H				
Skilled Nursing Facility	·			\$500.00					<u> </u>	
				2500.00						
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	•								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	✓ AII	☐ All			☐ All	☐ All			<b>☑</b> All	☐ All
Generics	V			\$10.00					V	
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	V			\$120.00					~	
Options for Additional Benefit Design Limits:		1	Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-FU						
Specialty Rx Coinsurance Maximum:	_		Plan HIOS ID:	41842DC001004	3-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):  Begin Primary Care Cost-Sharing After a Set Number of Visits?		-								
# Visits (1-10):	П									
Begin Primary Care Deductible/Coinsurance After a Set Number of	П									
Copays?										
# Copays (1-10):										
Output		J								
Calculate										
Status/Error Messages:	Error: Result is out	tside of [-4, +2] per	cent de minimis va	ariation.						
Actuarial Value:	72.77%									
Metal Tier:										
						vice with this co	st-sharing structure	is covered at	100% by the plan in	the deductible
Additional Notes:	range. NOTE: Offi	ce-visit-specific co	st-sharing is applyi	ng to x-rays in offic	ce settings.					
Calculation Time:	0.043 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option			ered Network Op				
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		. 4 Dl Dfit D-	-1	_	T'	2 Dl D 6'4 D	No1			
	Medical	r 1 Plan Benefit De	Combined	-	Medical	2 Plan Benefit D	Combined			
Deductible (\$)		Drug	\$2,600.00	-	iviedicai	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)			100.00%							
MOOP (\$)			\$6,700.00	†		-				
MOOP if Separate (\$)			\$0,700.00	<del>-1</del>						
(,,						•				
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	, after deductible
туре от венени	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	<b>☑</b> All	☐ All			All	☐ All			☐ All	☐ All
Emergency Room Services	V			\$150.00					v	
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	✓			\$25.00					✓	
					_					
Specialist Visit	V			\$50.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient	✓			\$50.00					✓	
Services										
Imaging (CT/PET Scans, MRIs)	V	V		ć2F 00						
Speech Therapy	V			\$25.00					V	
Occupational and Physical Therapy	✓			\$25.00					✓	
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services		<u> </u>								
X-rays and Diagnostic Imaging	✓	✓								
Skilled Nursing Facility	✓			\$500.00					✓	
		······································								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	✓ AII	☐ All			☐ All	☐ All			<b>☑</b> All	☐ All
Generics	V			\$10.00					V	
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	~			\$120.00					✓	
Options for Additional Benefit Design Limits:		1	Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-FU						
Specialty Rx Coinsurance Maximum:		-	Plan HIOS ID:	41842DC001004	3-01					
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):			Issuer HIOS ID:	41842						
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of		1								
Copays?										
# Copays (1-10):										
Output		1								
Calculate										
Status/Error Messages:	Error: Result is out	side of [-4, +2] per	cent de minimis va	ariation.						
Actuarial Value:	73.09%									
Metal Tier:										
						vice with this co	st-sharing structure	is covered at	100% by the plan in	the deductible
Additional Notes:	range. NOTE: Offi	ce-visit-specific co	st-sharing is applyi	ing to x-rays in offic	ce settings.					
Calculation Time:	0.0469 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?	✓		HSA/HRA Option:			ered Network Op				
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	i? □		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		1 Plan Benefit De	rian		Tion	2 Plan Benefit D	Aosian			
	Medical	Drug	Combined	+	Medical	Drug	Combined			
Deductible (\$)	Wiculcui	Diug	\$2,600.00	-	Wicalcar	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)			100.00%							
MOOP (\$)			\$6,700.00	7						
MOOP if Separate (\$)				<b>-</b>			·			
									1	
Click Here for Important Instructions		Tie					er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if		Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
Medical	Deductible?  ✓ All	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	□ All	☐ All
Emergency Room Services	✓ All			\$150.00					☑ All	
All Inpatient Hospital Services (inc. MH/SUD)	V			\$500.00					V	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	✓			\$25.00					✓	
Specialist Visit	✓			\$50.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient				¢50.00	_	_				_
Services	V			\$50.00					V	
Imaging (CT/PET Scans, MRIs)	V	V	61%	\$250.00						
Speech Therapy	V			\$25.00					V	
Occupational and Physical Therapy	✓			\$25.00					✓	
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	V	V								
X-rays and Diagnostic Imaging	V	V								
Skilled Nursing Facility	V			\$500.00					V	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	V	41%	\$250.00						
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	✓ AII	☐ All			☐ All	☐ All			✓ All	☐ All
Generics	V			\$10.00					V	
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	<b>V</b>			\$75.00					<b>▽</b>	
Specialty Drugs (i.e. high-cost)	✓			\$120.00					✓	
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?  Specialty Rx Coinsurance Maximum:			Name: Plan HIOS ID:	BH-FU_POST_ 41842DC0010043	2 01					
Set a Maximum Number of Days for Charging an IP Copay?	П		Issuer HIOS ID:	41842	3-01					
# Days (1-10):			issuel filos ib.	41042						
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):	_									
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate  Status (Free Message)	Calculation Suc	£1								
Status/Error Messages: Actuarial Value:	Calculation Success 69.23%	ıuı.								
Metal Tier:	Silver									
		services are not	subject to the ded	uctible and have no	copav. Anv ser	vice with this co	st-sharing structure	e is covered at	100% by the plan in	the deductible
Additional Notes:			-				-		vice(s) with fac/prof	
	overriding outpaties			- ,	<u> </u>		5		., ,,	• •
Calculation Time:	0.0391 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?	✓		HSA/HRA Options	5	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:		1st	Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Annual Contin	oution Amount.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		4 Dl D 6'4 D-	-1	П	T'	2 Di D 6'4 D	No1			
		1 Plan Benefit De	1	+		2 Plan Benefit D				
Deductible (\$)	Medical	Drug	\$2,600.00		Medical	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)			100.00%							
MOOP (\$)			\$6,700.00	+		L				
MOOP if Separate (\$)			\$0,700.00	_		T T	<del> </del>			
moor in separate (p)							1			
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
- (- (-	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	C	
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible
Medical	<b>✓</b> All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	V			\$150.00					✓	
All Inpatient Hospital Services (inc. MH/SUD)	<b>&gt;</b>			\$500.00		Ī			✓	
Drimon, Coro Visit to Treat on Injury or Illness (over Brownting and Visual)				¢3F 00	_	_				_
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<b>&gt;</b>			\$25.00					✓	
Specialist Visit	V			\$50.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient	0			\$50.00	П	П				_
Services	V			330.00	_				✓	
Imaging (CT/PET Scans, MRIs)	V	V	61%	\$250.00						
Speech Therapy	V			\$25.00					V	
Occupational and Physical Therapy	V			\$25.00					₹.	
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	N	V								
X-rays and Diagnostic Imaging	>	<b>V</b>								
Skilled Nursing Facility	V			\$500.00					V	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	✓								
Outpatient Surgery Physician/Surgical Services	V	<b>V</b>								
Drugs	✓ All	☐ All			☐ All	☐ All			✓ All	☐ All
Generics	<b>V</b>			\$10.00					✓	
Preferred Brand Drugs	<b>\</b>			\$40.00					✓	
Non-Preferred Brand Drugs	>			\$75.00					V	
Specialty Drugs (i.e. high-cost)	V			\$120.00					V	
Options for Additional Benefit Design Limits:			Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-FU_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC0010043	3-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays? # Copays (1-10):										
Output # Copays (1-10).										
Calculate										
	Error: Result is out	side of [-4 +2] nor	rent de minimis va	riation						
	72.06%	o. [ 4, ·2] per	ac ./////////////////////							
Metal Tier:										
	NOTE: One or mor	e services are not	subject to the ded	uctible and have no	copay. Anv ser	vice with this co	st-sharing structure	is covered at	100% by the plan in	the deductible
Additional Notes:	range. NOTE: Office								,	
	<u> </u>		3	- ,	J-					
Calculation Time:	0.0742 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?	✓		HSA/HRA Option:	s	Tie	red Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		7 mindar Content			2nd	l Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_	_					
		1 Plan Benefit De	1			2 Plan Benefit [				
Double still - (A)	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$) Coinsurance (%, Insurer's Cost Share)			\$2,600.00 100.00%							
MOOP (\$)			\$6,700.00	-						
MOOP if Separate (\$)			\$0,700.00	_		T				
moor in separate (y)			-				1			
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
Town of Donnella	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Canau annliae anh	. aftau dad. atible
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	arter deductible
Medical	✓ All	☐ All			All	☐ All			☐ All	All
Emergency Room Services	✓			\$150.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	V	✓								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	✓			\$25.00					✓	
				\$25.00	_					
Specialist Visit	V			\$50.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient	<b>v</b>			\$50.00					✓	
Services										
Imaging (CT/PET Scans, MRIs)	<b>V</b>	<u> </u>	61%	\$250.00						
Speech Therapy	V			\$25.00					V	
Conventional and Dhysical Thoragu	✓			\$25.00					✓	
Occupational and Physical Therapy Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	☑	✓								
X-rays and Diagnostic Imaging	V	<u>v</u>				Ä				
Skilled Nursing Facility	<b>V</b>			\$500.00					<u> </u>	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	V	41%	\$250.00						
Outpatient Surgery Physician/Surgical Services	V	✓								
Drugs	✓ All	☐ All			☐ All	☐ All			<b>☑</b> All	☐ All
Generics	V			\$10.00					V	
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	•			\$120.00					V	
Options for Additional Benefit Design Limits:	_		Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-FU_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001004	3-01					
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):			Issuer HIOS ID:	41842						
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	ful.								
Actuarial Value:	69.36%									
Metal Tier:	Silver									
									100% by the plan in	
Additional Notes:				ng to x-rays in offic	ce settings. NOT	E: Service-speci	ic cost-sharing is a	pplying for ser	vice(s) with fac/prof	components,
	overriding outpatie	nt inputs for those	e service(s).							
Calculation Time:	0.0352 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?	✓		HSA/HRA Options			ered Network Op	tion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		4 Dl D ft D.	-1		T1	2 Dl D 6'4 D	!			
	Medical	r 1 Plan Benefit De	Combined	-	Medical	2 Plan Benefit D	Combined			
Deductible (\$)	iviedicai	Drug	\$2,600.00	-	iviedicai	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)			100.00%							
MOOP (\$)			\$6,700.00	†		-				
MOOP if Separate (\$)			\$0,700.00	_1						
(,,						•	ı			
Click Here for Important Instructions		Tie	er 1			Tie	er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
туре от венени	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	<b>✓</b> All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	v			\$150.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	V	✓								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<b>&gt;</b>			\$25.00					✓	
Specialist Visit	V			\$50.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient	•			\$50.00					✓	
Services		☑	540/		_					
Imaging (CT/PET Scans, MRIs)	<b>.</b>	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	61%	\$250.00						
Speech Therapy	V			\$25.00					V	
Occupational and Physical Therapy	V			\$25.00					✓	
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	] [3]	<u> </u>								
X-rays and Diagnostic Imaging	·	<b>V</b>			_	Ä				
Skilled Nursing Facility				\$500.00					<u> </u>	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Y	V								
Outpatient Surgery Physician/Surgical Services	>	V								
Drugs	<b>▼</b> All	☐ All			☐ All	☐ All			✓ All	☐ All
Generics	V			\$10.00					V	
Preferred Brand Drugs	>			\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	V			\$120.00					~	
Options for Additional Benefit Design Limits:	_	1	Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?	Ш		Name:	BH-FU_POST_						
Specialty Rx Coinsurance Maximum:	_	-	Plan HIOS ID:	41842DC001004	3-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):		-								
Begin Primary Care Cost-Sharing After a Set Number of Visits?  # Visits (1-10):	Ш									
Begin Primary Care Deductible/Coinsurance After a Set Number of	П									
Copays?	ш									
# Copays (1-10):										
Output		J								
Calculate										
Status/Error Messages:	Error: Result is out	tside of [-4, +2] per	cent de minimis va	ariation.						
Actuarial Value:	72.35%									
Metal Tier:										
						vice with this co	st-sharing structure	is covered at	100% by the plan in	the deductible
Additional Notes:	range. NOTE: Offi	ice-visit-specific co	st-sharing is applyi	ng to x-rays in offic	ce settings.					
Calculation Time:	0.043 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:	s	Tie	ered Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			t Tier Utilization				
Use Separate MOOP for Medical and Drug Spending?		7 ii ii idai Comen	bation / anoant.		2nd	d Tier Utilization				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_						
		r 1 Plan Benefit De	1			2 Plan Benefit				
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,000.00	\$250.00								
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%		-						
MOOP (\$)	\$6,0	00.00								
MOOP if Separate (\$)										
Click Here for Important Instructions		Tie	or 1			т	ier 2		Tier 1	Tier 2
CHECK THEFE TOT IMPORTANT HISTOCHOTS	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?		separate	Copay applies only	y after deductible?
Medical	□ All	□ All	uniciciit	эсрагасс	□ All	□ All	uniciciit	Separate	□ All	☐ All
Emergency Room Services	✓			\$500.00					<b>V</b>	
All Inpatient Hospital Services (inc. MH/SUD)	v v			\$500.00	Ī	ā			Z	Ī
***************************************										
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit	V			\$60.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient										· · · · · · · · · · · · · · · · · · ·
Services				\$60.00						
Imaging (CT/PET Scans, MRIs)	V	✓	76%	\$150.00						
Speech Therapy				\$30.00						
				400.00						П
Occupational and Physical Therapy		Ш		\$30.00		Ш				
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	V	V								
X-rays and Diagnostic Imaging	>	✓								
Skilled Nursing Facility	V			\$500.00					V	
Outpotiont Facility Foo (a.g., Ambulaton Gurgon Conton)	V	V	63%	\$150.00		П				П
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)			03%	\$150.00						Ш
Outpatient Surgery Physician/Surgical Services	N	V								
Drugs	☐ All	☐ AII			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	<b>V</b>			\$75.00					<u> </u>	
Specialty Drugs (i.e. high-cost)	V			\$120.00					V	
Options for Additional Benefit Design Limits:		1	Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?	Ш		Name:	BH-FV						
Specialty Rx Coinsurance Maximum:	_	-	Plan HIOS ID:	41842DC004006	4-01					
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):			Issuer HIOS ID:	41842						
Begin Primary Care Cost-Sharing After a Set Number of Visits?		-								
# Visits (1-10):	Ш									
Begin Primary Care Deductible/Coinsurance After a Set Number of	П	-								
Copays?										
# Copays (1-10):										
Output		1								
Calculate										
	Error: Result is out	tside of [-4. +2] ner	rcent de minimis va	ariation.						
	75.96%	, ., _, pc.								
Metal Tier:										
	NOTE: One or mor	re services are not	subject to the ded	uctible and have no	o copay. Any sei	rvice with this co	st-sharing structure	e is covered at	100% by the plan in	the deductible
Additional Notes:							_		vice(s) with fac/pro	
, additional recov		ent inputs for those		3	0			,	,	F/
Calculation Time:	0.0469 seconds		• •							
Final 2019 AV Calculator	5.5 705 30001103									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:		1st	t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Annual Contin	button Amount.		2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_						
		Plan Benefit De				2 Plan Benefit D				
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,000.00	\$250.00								
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$6,000	.00								
MOOP if Separate (\$)							l			
Clieb Hore for Important Instructions		T:	er 1			т:	er 2		Tier 1	Tier 2
Click Here for Important Instructions	Cublanta			C 16	Culti- at ta			C 'f	Her 1	Her 2
Type of Benefit	Subject to	Subject to	Coinsurance, if		Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
A4-di-d	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	☐ All	□ All
Medical	✓ All			ĆE 00 00	_				□ All	
Emergency Room Services	V			\$500.00					V	
All Inpatient Hospital Services (inc. MH/SUD)		Ш		\$500.00	Ш				<u> </u>	Ш
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Constitution of the consti	<b>V</b>			¢50.00					V	
Specialist Visit		Ш		\$60.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient Services				\$60.00						
Imaging (CT/PET Scans, MRIs)	V	✓	76%	\$150.00						
Speech Therapy			70%	\$30.00						
Зрееси піетару				\$30.00						
Occupational and Physical Therapy				\$30.00						
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	_ _	<u> </u>								
X-rays and Diagnostic Imaging	V	<b>V</b>			_					
Skilled Nursing Facility	<b>V</b>			\$500.00					<u> </u>	
				<b>3300.00</b>						
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓								
Outpatient Surgery Physician/Surgical Services	<b>V</b>	✓								
Drugs	All	☐ All			□ All	All			All	
Generics				\$10.00						
Preferred Brand Drugs				\$40.00					<u> </u>	
Non-Preferred Brand Drugs				\$75.00					<u> </u>	
Specialty Drugs (i.e. high-cost)	<u> </u>			\$120.00					V	
Options for Additional Benefit Design Limits:			Plan Description:	:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-FV						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC0040064	4-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
,	Calculation Successf	ul.								
	77.96%									
Metal Tier:	Gold									
	NOTE: One or more	services are not	subject to the ded	uctible and have no	copay. Any ser	rvice with this co	st-sharing structure	e is covered at	100% by the plan in	the deductible
Additional Notes:	range. NOTE: Office	-visit-specific co	st-sharing is applyi	ing to x-rays in offic	ce settings.					
Calculation Time:	0.0469 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Options		Tie	red Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			Tier Utilization				
Use Separate MOOP for Medical and Drug Spending?		71111001 001101	bactott / titlo arte.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_						
		1 Plan Benefit De	1	-		2 Plan Benefit I				
Destructible (A)	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,000.00 100.00%	\$250.00 100.00%								
Coinsurance (%, Insurer's Cost Share) MOOP (\$)	\$6,000			-	-	ļ				
MOOP (\$)  MOOP if Separate (\$)	\$6,000	0.00		-						
WOOF II Separate (5)							1			
Click Here for Important Instructions		Tie	er 1			Т	ier 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies onl	y after deductible
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	✓			\$500.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	✓	✓								
				400.00		_				
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit	V			\$60.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00	_	П				П
Services										
Imaging (CT/PET Scans, MRIs)	V	✓	76%	\$150.00						
Speech Therapy				\$30.00						
				\$30.00						
Occupational and Physical Therapy				755.55						
Preventive Care/Screening/Immunization										_
Laboratory Outpatient and Professional Services	V	<u> </u>								
X-rays and Diagnostic Imaging	<b>V</b>	<u> </u>		4500.00						
Skilled Nursing Facility	V			\$500.00					V	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓	63%	\$150.00						
Outpoblish Curson, Physician / Cursinal Continue	V	V								
Outpatient Surgery Physician/Surgical Services  Drugs	□ All	□ All			□ All	□ All			□ All	□ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00					<u> </u>	
Non-Preferred Brand Drugs	·	Ö		\$75.00	ä				☑ ✓	
Specialty Drugs (i.e. high-cost)	<u> </u>			\$120.00					✓	
Options for Additional Benefit Design Limits:			Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-FV						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC0040064	4-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output Calculate										
	Calculation Success	ful								
	76.10%	rui.								
	Gold									
	NOTE: One or more	services are not	subject to the dedi	uctible and have no	copay. Any ser	vice with this co	st-sharing structure	e is covered at	100% by the plan in	the deductible
Additional Notes:	range. NOTE: Office		-				_			
	overriding outpatier			_ ,	J		. 0.92		.,	,
Calculation Time:	0.0547 seconds	•								
Final 2019 AV Calculator	2.33.7.30001103									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:		1s	t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Annual Contin	bution Amount.		2nd	d Tier Utilization:	:			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Gold ▼									
	Tier:	L Plan Benefit De	esign		Tie	r 2 Plan Benefit [	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,000.00	\$250.00								
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$6,000	0.00								
MOOP if Separate (\$)										
Click Here for Important Instructions			er 1				ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductib
	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	V			\$500.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit	_			\$60.00		П				
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00					•	
Services				\$60.00						
Imaging (CT/PET Scans, MRIs)	V	✓	76%	\$150.00						
Speech Therapy				\$30.00						
				·····						
Occupational and Physical Therapy				\$30.00						
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	V	V								
X-rays and Diagnostic Imaging	V	✓								
Skilled Nursing Facility	V			\$500.00					V	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	<b>v</b>								
		<u> </u>				П				
Outpatient Surgery Physician/Surgical Services					□ All	□ All				
Drugs	□ AII	□ All		440.00					□ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	N C			\$40.00					Ŋ.	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	V			\$120.00					✓	
Options for Additional Benefit Design Limits:			Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-FV						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC0040064	4-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):	_									
Begin Primary Care Cost-Sharing After a Set Number of Visits?  # Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Successi	ful.								
Actuarial Value:	78.19%									
Metal Tier:	Gold									
						rvice with this co	st-sharing structure	is covered at	100% by the plan in	the deductible
Additional Notes:	range. NOTE: Office	e-visit-specific co	st-sharing is applyi	ing to x-rays in offic	ce settings.					
Calculation Time:	0.0547 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:	s	Tie	ered Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			t Tier Utilization				
Use Separate MOOP for Medical and Drug Spending?		7 miliaar corners	oution, and and		2nd	d Tier Utilization	:			
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		4 Dl D ft D.	-1		T1	2 Dl D 6'4 l	Dara'ana			
	Medical	r 1 Plan Benefit De	Combined	-	Medical	2 Plan Benefit	Combined			
Deductible (\$)		<b>Drug</b> \$250.00	Combined		iviedicai	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)		00.00								
MOOP if Separate (\$)	\$0,0	00.00		-						
			•				-			
Click Here for Important Instructions		Tie	er 1			Т	ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Consy applies onl	y after deductible?
туре от венени	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	copay applies offi	y arter deductible:
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	✓			\$500.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	V			\$500.00					V	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
					_					_
Specialist Visit	V			\$60.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00						
Services Imaging (CT/PET Scans, MRIs)		_	53%	\$300.00						
Speech Therapy			33/6	\$30.00		_				
эреситиетару										
Occupational and Physical Therapy				\$30.00						
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	✓	<u> </u>								
X-rays and Diagnostic Imaging		<u> </u>								
Skilled Nursing Facility	✓			\$500.00					✓	
	V	✓	27%	¢200.00		П				П
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)			2/70	\$300.00		_				_
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ AII	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	_			\$40.00					_	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	•		Plan Description	\$120.00	L				V	Ш
Options for Additional Benefit Design Limits:  Set a Maximum on Specialty Rx Coinsurance Payments?		1	Name:	BH-FV_POST						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC0040064	4-01					
Set a Maximum Number of Days for Charging an IP Copay?	П	1	Issuer HIOS ID:	41842	- 01					
# Days (1-10):	_									
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:		tside of [-4, +2] per	cent de minimis va	ariation.						
Actuarial Value:	74.63%									
Metal Tier:	NOTE: One or or	ro condicos see e - t	cubioce ec ebo d	uctible and barre	consu Amiri-	nuinn with thin	oct charing stand	ie covered -+	100% by the ale: !:	the deductible
Additional Nation			-				-		100% by the plan in vice(s) with fac/pro	
Additional Notes:		ent inputs for those		ing to x-rays in Offic	e settings. NO	i L. Bei vice-speci	inic cost-snaming is a	philing ioi sei	vice(s) with rac/pro	components,
Calculation Times	= :	cpats for those	C 3C. VICC(3).							
Calculation Time:	0.0742 seconds									
Final 2019 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:	s	Tie	ered Network Op	tion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Annual Contin	button Amount.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_						
		Plan Benefit De		_		2 Plan Benefit D				
- L .: L .: A	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,000.00	\$250.00								
Coinsurance (%, Insurer's Cost Share) MOOP (\$)	100.00%	100.00%		-		ļ				
MOOP (\$)  MOOP if Separate (\$)	\$6,000	.00		_						
WOOF II Separate (3)							Į.			
Click Here for Important Instructions		Tie	er 1			Tie	er 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible
Medical	□ All	□ All			☐ All	□ All			☐ All	☐ All
Emergency Room Services	✓			\$500.00		<u> </u>				
All Inpatient Hospital Services (inc. MH/SUD)	<u> </u>			\$500.00					✓	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit	V			\$60.00					✓	
Mental/Behavioral Health and Substance Use Disorder Outpatient	_	_		450.00	_				_	
Services				\$60.00						
Imaging (CT/PET Scans, MRIs)	V	V	53%	\$300.00						
Speech Therapy				\$30.00						
				\$30.00						
Occupational and Physical Therapy				\$50.00						
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	<u> </u>	<u> </u>								
X-rays and Diagnostic Imaging	<b>V</b>	<b>V</b>								
Skilled Nursing Facility	V			\$500.00					V	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	V								
Outpatient Surgery Physician/Surgical Services	>	V								
Drugs	☐ All	☐ AII			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					<u> </u>	
Specialty Drugs (i.e. high-cost)	V			\$120.00					~	
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-FV_POST_	4.04					
Specialty Rx Coinsurance Maximum:  Set a Maximum Number of Days for Charging an IP Copay?			Plan HIOS ID: Issuer HIOS ID:	41842DC0040064 41842	4-01					
# Days (1-10):			issuer HIOS ID:	41842						
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?	_									
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Successf	ul.								
	77.55%									
	Gold									
	NOTE: One or more		-			rvice with this co	st-sharing structure	is covered at	100% by the plan in	the deductible
Additional Notes:	range. NOTE: Office	-visit-specific co	st-sharing is applyi	ing to x-rays in offic	e settings.					
Calculation Time:	0.082 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Tie	red Network Op	tion			
Apply Inpatient Copay per Day?		HSA/HRA Empl	oyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	oution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	Gold ▼									
Desired Metal Tier		r 1 Plan Benefit De	cian		Tion	2 Plan Benefit D	Nosian			
	Medical	Drug	Combined	+	Medical	Drug	Combined			
Deductible (\$)	\$2,000.00	\$250.00	Combined		Wicalcai	Diug	Compilica			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$6,0	00.00				'				
MOOP if Separate (\$)				-						
Click Here for Important Instructions		Tie					er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible?
	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☐ All	□ All		4500.00	All	All			□ All	☐ All
Emergency Room Services	V	□ ☑		\$500.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	V					Ц				
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit	V			\$60.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$60.00						
Services										
Imaging (CT/PET Scans, MRIs)	V	V	53%	\$300.00						
Speech Therapy				\$30.00						
Occupational and Physical Therapy				\$30.00						
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	V	V								
X-rays and Diagnostic Imaging	N	✓								
Skilled Nursing Facility	· ·			\$500.00					V	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	•	27%	\$300.00						
Outpatient Surgery Physician/Surgical Services	V	✓								
Drugs	□ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	N			\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	•			\$120.00					~	
Options for Additional Benefit Design Limits:		7	Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?	Ш		Name:	BH-FV_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004006	4-01					
Set a Maximum Number of Days for Charging an IP Copay?	Ш		Issuer HIOS ID:	41842						
# Days (1-10):  Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output		_								
Calculate										
Status/Error Messages:		tside of [-4, +2] per	cent de minimis va	riation.						
Actuarial Value:	74.72%									
Metal Tier:	NOTE: O		and the second second				an abandara d		4000/	de a calacado de 1900.
							_		100% by the plan in	
Additional Notes:	-	ent inputs for those		ing to x-rays in offic	Le settings. NOI	E: Service-specif	ic cost-snaring is a	ppiying for ser	vice(s) with fac/prof	components,
		ent inputs 101 til0se	service(s).							
Calculation Time:	0.0508 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:		1s	t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?	_	7 mindar Conten	bacion / uno aric.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				=						
		1 Plan Benefit De	, -			2 Plan Benefit D	_			
(4)	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,000.00	\$250.00								
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%		-						
MOOP (\$)	\$6,000	).00								
MOOP if Separate (\$)							l			
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies onl	after deductible
Medical	All	☐ All			☐ All	□ All			☐ All	☐ All
Emergency Room Services	✓			\$500.00					<u> </u>	
All Inpatient Hospital Services (inc. MH/SUD)	✓	<u> </u>								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$30.00						
Specialist Visit	V			\$60.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient	_	_		450.00	_	_			_	_
Services				\$60.00						
Imaging (CT/PET Scans, MRIs)	V	V	53%	\$300.00						
Speech Therapy				\$30.00						
				\$30.00						
Occupational and Physical Therapy				\$30.00		_				_
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	V	✓								
X-rays and Diagnostic Imaging	V	V								
Skilled Nursing Facility	V			\$500.00					V	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<b>&gt;</b>	•								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	>			\$120.00					V	
Options for Additional Benefit Design Limits:			Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-FV_POST_						
Specialty Rx Coinsurance Maximum:	_		Plan HIOS ID:	41842DC0040064	4-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):  Begin Primary Care Cost-Sharing After a Set Number of Visits?	_									
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	ful.								
Actuarial Value:	77.78%									
Metal Tier:	Gold									
	NOTE: One or more	services are not	subject to the ded	uctible and have no	copay. Any sei	rvice with this co	st-sharing structure	is covered at	100% by the plan in	the deductible
Additional Notes:	range. NOTE: Office	e-visit-specific co	st-sharing is applyi	ng to x-rays in offic	ce settings.					
Calculation Time:	0.0781 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:	s	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Empl	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		7 ii ii dar Corieri	oacion, ano anci		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Platinum 🔻	451 5 615		_	_					
		r 1 Plan Benefit De	1			2 Plan Benefit D				
Deductible (\$)	<b>Medical</b> \$250.00	<b>Drug</b> \$0.00	Combined		Medical	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)		00.00		<del>-</del>		L				
MOOP if Separate (\$)		50.00		_						
			•			-				
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
- (- (-	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	C	- 60
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible
Medical	☐ All	☐ All			All	☐ All			□ All	☐ All
Emergency Room Services				\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$15.00						
Specialist Visit				\$30.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$30.00						
Services	L				_					
Imaging (CT/PET Scans, MRIs)	<u> </u>	<u> </u>		445.00						
Speech Therapy				\$15.00						
Occupational and Physical Therapy				\$15.00						
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services				\$30.00						
X-rays and Diagnostic Imaging				\$30.00						
Skilled Nursing Facility	✓	✓								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	V								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			□ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$100.00						
Options for Additional Benefit Design Limits:		1	Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-FW						
Specialty Rx Coinsurance Maximum:	_		Plan HIOS ID:	41842DC0010066	6-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):  Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of	П									
Copays?										
# Copays (1-10):										
Output		1								
Calculate										
Status/Error Messages:	Calculation Succes	sful.								
Actuarial Value:	89.58%									
Metal Tier:	Platinum									
	NOTE: One or mor	e services are not	subject to the ded	uctible and have no	copay. Any ser	vice with this co	st-sharing structure	is covered at	100% by the plan in	the deductible
Additional Notes:	range.									
Calculation Time:	0.0508 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Tie	red Network Op	tion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:		1st	Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Ailidai Contin	bution Amount.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Platinum ▼			_						
		r 1 Plan Benefit De	1			2 Plan Benefit D				
Doducatible (C)	<b>Medical</b> \$250.00	Drug	Combined		Medical	Drug	Combined			
Deductible (\$) Coinsurance (%, Insurer's Cost Share)	100.00%	\$0.00 100.00%								
MOOP (\$)		00.00				1				
MOOP (\$)	\$2,5	1		-						
MOOF II Separate (3)							l			
Click Here for Important Instructions		Tie	er 1			Tie	er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services				\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$15.00						
Specialist Visit				\$30.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$30.00	_	_				_
Services				\$30.00						
Imaging (CT/PET Scans, MRIs)	V	V	58%	\$250.00						
Speech Therapy				\$15.00						
Occupational and Physical Therapy				\$15.00						
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services				\$30.00						
X-rays and Diagnostic Imaging				\$30.00						
Skilled Nursing Facility	✓	✓								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	V	37%	\$250.00						
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	□ All	□ All			□ All	□ All			□ All	□ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$100.00						
Options for Additional Benefit Design Limits:			Plan Description	:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-FW_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001006	6-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):		-								
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	П									
# Copays (1-10):										
Output		ı								
Calculate										
	Calculation Succe	ssful.								
	88.02%									
	Platinum									
	NOTE: One or mo	re services are not	subject to the ded	uctible and have no	copay. Any ser	vice with this co	st-sharing structure	is covered at	100% by the plan in	the deductible
Additional Notes:	range. NOTE: Ser	vice-specific cost-s	haring is applying f	or service(s) with fa	ac/prof compon	ents, overriding o	outpatient inputs fo	or those service	e(s).	
Calculation Time:	0.0586 seconds									

Calculation Time:

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		7 mildar correin			2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Platinum 🔻	4.51 5 61.5			_					
		r 1 Plan Benefit De	1			2 Plan Benefit D				
Deductible (\$)	<b>Medical</b> \$250.00	<b>Drug</b> \$0.00	Combined		Medical	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)		00.00		-		L				
MOOP if Separate (\$)	\$2,3	00.00		-						
moor ii separate (y)							1			
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	6	- 64 11 421-1 - 1
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	atter deductible
Medical	☐ All	☐ All			All	☐ All			☐ All	☐ All
Emergency Room Services				\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)	V	✓								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$15.00						
Specialist Visit				\$30.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient										
Services				\$30.00						
Imaging (CT/PET Scans, MRIs)	V	✓	58%	\$250.00						
Speech Therapy				\$15.00						
				\$15.00						
Occupational and Physical Therapy	0			\$15.00		-				_
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services				\$30.00						
X-rays and Diagnostic Imaging				\$30.00						
Skilled Nursing Facility	V	~								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	V								
Outpatient Surgery Physician/Surgical Services	>	V								
Drugs	☐ All	☐ AII			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$100.00						
Options for Additional Benefit Design Limits:		1	Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?  Specialty Rx Coinsurance Maximum:			Name: Plan HIOS ID:	BH-FW_POST_ 41842DC001006	6 01					
Set a Maximum Number of Days for Charging an IP Copay?	П	-	Issuer HIOS ID:	41842	0-01					
# Days (1-10):			issuel filos ib.	41042						
Begin Primary Care Cost-Sharing After a Set Number of Visits?	П	1								
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of		1								
Copays?										
# Copays (1-10):										
Output  Calculate										
	Calculation Succes	eeful								
- · · · · · · · · · · · · · · · · · · ·	89.13%	oorui.								
	Platinum									
		re services are not	subject to the ded	uctible and have no	copay. Any ser	vice with this co	st-sharing structure	is covered at	100% by the plan in	he deductible
Additional Notes:	range.			and have no			5			acaactibic
Additional Hotes.	. 3									
Calculation Time:	0.0469 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:	s	Tie	red Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiered	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		7 miliaar correin			2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		451 5 615			_					
		1 Plan Benefit De	1	-		2 Plan Benefit D				
Deductible (\$)	<b>Medical</b> \$750.00	<b>Drug</b> \$0.00	Combined		Medical	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)	80.00%	100.00%								
MOOP (\$)		00.00		-						
MOOP (\$)	Ç0,30	0.00		-						
moor ii separate (y)			-				1			
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		6. 1.1
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	V	V								
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$20.00						
Primary Care visit to Treat an injury or lilliess (exc. Preventive, and x-rays)				\$20.00	_					
Specialist Visit				\$40.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$40.00						
Services				Ş40.00	l .					
Imaging (CT/PET Scans, MRIs)	V	V								
Speech Therapy				\$20.00						
				\$20.00						
Occupational and Physical Therapy					_					
Preventive Care/Screening/Immunization										_
Laboratory Outpatient and Professional Services	<b>V</b>	<u> </u>								
X-rays and Diagnostic Imaging	<u> </u>	<u> </u>								
Skilled Nursing Facility										
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	$\checkmark$	V								
Outpatient Surgery Physician/Surgical Services	<b>V</b>	<b>V</b>								
Drugs	☐ All	☐ All			☐ All	☐ All			□ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$120.00						
Options for Additional Benefit Design Limits:			Plan Description	:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-FX						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001003	2-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):	_									
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):  Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
	Error: Result is out	side of [-4, +2] per	cent de minimis va	ariation.						
	82.50%									
Metal Tier:										
	NOTE: One or mor	e services are not	subject to the ded	uctible and have no	copay. Any ser	vice with this co	st-sharing structure	e is covered at	100% by the plan in	the deductible
Additional Notes:	range. NOTE: Office	ce-visit-specific co	st-sharing is applyi	ng to x-rays in offic	ce settings.					
Calculation Time:	0.0312 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			<b>HSA/HRA Option</b>	s	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	i? □	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:		1s	t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Annual Contin	bution Amount.		2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Gold ▼									
	Tier	1 Plan Benefit De	sign		Tier	r 2 Plan Benefit [	Design			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$750.00	\$0.00								
Coinsurance (%, Insurer's Cost Share)	80.00%	100.00%								
MOOP (\$)	\$6,50	0.00				•				
MOOP if Separate (\$)				-						
			-			•	•			
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if		Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible?
na diad	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		□ All
Medical		□ All							□ All	
Emergency Room Services	V									
All Inpatient Hospital Services (inc. MH/SUD)	V	~			Ш	Ш				Ш
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$20.00						
Casalala Visit				\$40.00						
Specialist Visit				\$40.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$40.00						
Services	V	✓	49%	\$250.00						
Imaging (CT/PET Scans, MRIs)			49%	\$250.00						
Speech Therapy				\$20.00						
Occupational and Physical There are				\$20.00						
Occupational and Physical Therapy					_	_				
Preventive Care/Screening/Immunization Laboratory Outpatient and Professional Services		<b>□</b>								
	V	V								
X-rays and Diagnostic Imaging										
Skilled Nursing Facility	✓	V								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓	31%	\$250.00						
Outpatient Surgery Physician/Surgical Services	V	<b>V</b>								
Drugs	□ All	□ All			□ All				□ All	
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00	_					
Specialty Drugs (i.e. high-cost)				\$120.00						
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-FX POST						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001003	2-01					
Set a Maximum Number of Days for Charging an IP Copay?	П		Issuer HIOS ID:	41842	2 01					
# Days (1-10):			issuci filos ib.	41042						
Begin Primary Care Cost-Sharing After a Set Number of Visits?	П									
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of	П									
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	ful.								
Actuarial Value:	79.83%									
Metal Tier:	Gold									
		services are not	subject to the ded	uctible and have no	o copav. Anv sei	rvice with this co	st-sharing structur	e is covered at	t 100% by the plan in	the deductible
Additional Notes:			-				_		rvice(s) with fac/prof	
Additional Notes.	overriding outpatie			J					,-,	
Coloriation Times										
Calculation Time:	0.0312 seconds									
Final 2019 AV Calculator										

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:	s	Tie	ered Network Op	tion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		r 1 Plan Benefit De	sian		Tion	r 2 Plan Benefit D	locian			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$750.00	\$0.00	Combined		Wicalcai	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)	80.00%	100.00%								
MOOP (\$)		00.00								
MOOP if Separate (\$)				-			•			
Click Here for Important Instructions			er 1				er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if		Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
Medical	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	☐ All	□ All
Emergency Room Services	V All	V								
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$20.00						
Specialist Visit				\$40.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient	_	_			_					
Services				\$40.00						
Imaging (CT/PET Scans, MRIs)	V	✓	49%	\$250.00						
Speech Therapy				\$20.00						
Occupational and Physical Therapy				\$20.00						
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	V	V								
X-rays and Diagnostic Imaging	V	V								
Skilled Nursing Facility	V	✓								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	•	•								
Outpatient Surgery Physician/Surgical Services	V	✓								
Drugs	☐ All	☐ All			☐ All	☐ All			□ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$120.00		Ш				
Options for Additional Benefit Design Limits:		1	Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?  Specialty Rx Coinsurance Maximum:			Name: Plan HIOS ID:	BH-FX_POST_ 41842DC001003	2.01					
Set a Maximum Number of Days for Charging an IP Copay?	П		Issuer HIOS ID:	41842	2-01					
# Days (1-10):			133461 11103 15.	41042						
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output Calculate										
Status/Error Messages:	Error: Result is out	side of [-4. +2] ner	cent de minimis va	ariation.						
Actuarial Value:	82.01%	, _, pe.								
Metal Tier:										
	NOTE: One or mor	e services are not	subject to the ded	uctible and have no	o copay. Any sei	rvice with this co	st-sharing structure	is covered at	100% by the plan in	the deductible
Additional Notes:	range. NOTE: Offi	ce-visit-specific co	st-sharing is applyi	ing to x-rays in offic	ce settings.					
Calculation Time:	0.0391 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Empl	oyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contrib	oution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		1 Plan Benefit De	alau.	_	Tion	2 Plan Benefit D	a sign			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,500.00	\$250.00	Combined		ivieuicai	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%								
MOOP (\$)	\$7,90			Ī						
MOOP if Separate (\$)				-						
Click Here for Important Instructions		Tie	r 1				er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	□ All	□ All			All	All			□ All	All
Emergency Room Services	V	<b>▽</b>								
All Inpatient Hospital Services (inc. MH/SUD)		<u> </u>								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$50.00						
Specialist Visit				\$100.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient						· · · · · · · · · · · · · · · · · · ·				
Services				\$100.00						
Imaging (CT/PET Scans, MRIs)		✓	54%	\$299.97						
Speech Therapy				\$50.00						
				\$50.00						
Occupational and Physical Therapy				<b>\$30.00</b>					_	
Preventive Care/Screening/Immunization	_									
Laboratory Outpatient and Professional Services	V	V								
X-rays and Diagnostic Imaging	<b>&gt;</b>	<b>▽</b>								
Skilled Nursing Facility										
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		V	29%	\$212.45						
Outpatient Surgery Physician/Surgical Services	✓	V								
Drugs	☐ AII	☐ All			☐ All	☐ All			□ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	<b>V</b>			\$120.00					✓	
Options for Additional Benefit Design Limits:			Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:			Name: Plan HIOS ID:	BH-FY 41842DC0040101	1 01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842	1-01					
# Days (1-10):			issuel filos ib.	41042						
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):	_									
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate Status /Error Mossages:	Calculation Sugar	fl								
Status/Error Messages: Actuarial Value:	Calculation Success 70.12%	iui.								
Metal Tier:	70.12% Silver									
The contract of the contract o		services are not	subject to the ded	uctible and have no	copay. Any ser	vice with this co	st-sharing structure	is covered at	100% by the plan in	the deductible
Additional Notes:							-		vice(s) with fac/prof	
	overriding outpatie			- ,	5		3		., ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	. ,
Calculation Time:	0.0352 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	5	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Empl	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		, unidar content	oution / uniouniti		2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		4 Dl D 6'4 D-	-1		T1	2 Dl D 6'4 F	N			
	Medical	1 Plan Benefit De	Combined	-	Medical	2 Plan Benefit I	Combined			
Deductible (\$)	\$2,500.00	<b>Drug</b> \$250.00	Combined	-	Medical	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%								
MOOP (\$)	\$7,90			<b>-</b>		1				
MOOP if Separate (\$)				-						
,			•				•			
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
туре от венени	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☐ All	☐ All			☐ All	All			☐ All	☐ All
Emergency Room Services	V	V								
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$50.00						
Specialist Visit				\$100.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient										
Services				\$100.00						
Imaging (CT/PET Scans, MRIs)		<b>V</b>	54%	\$299.97						
Speech Therapy				\$50.00						
Occupational and Physical Therapy				\$50.00						
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	<u></u>	v			_					
X-rays and Diagnostic Imaging		✓								
Skilled Nursing Facility	✓	✓								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		v			_					
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	□ All	□ All			□ All	□ All			□ All	□ All
Generics				\$10.00						
Preferred Brand Drugs	✓			\$40.00					✓	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	V			\$120.00					V	
Options for Additional Benefit Design Limits:			Plan Description:	:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-FY						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC0040101	1-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Success	ful.								
Actuarial Value:	71.88%									
Metal Tier:	Silver									
			-				-		100% by the plan in	
Additional Notes:				ng to x-rays in offic	e settings. NO	ΓΕ: Service-speci	fic cost-sharing is a	pplying for se	rvice(s) with fac/prof	components,
	overriding outpatie	nt inputs for those	e service(s).							
Calculation Time:	0.0391 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:	s	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		. Plan Benefit De	scian		Tion	r 2 Plan Benefit D	Nosian			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,500.00	\$250.00	Combined		Wiculcui	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%								
MOOP (\$)	\$7,900									
MOOP if Separate (\$)				-			<u>'</u>			
Click Here for Important Instructions			er 1				er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if		Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
·	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☐ AII	□ All			All	All			□ All	All
Emergency Room Services All Inpatient Hospital Services (inc. MH/SUD)	V	<b>V</b>								
All impatient riospital services (inc. Willy 300)										
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$50.00						
Specialist Visit				\$100.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient										
Services				\$100.00						
Imaging (CT/PET Scans, MRIs)		V	54%	\$299.97						
Speech Therapy				\$50.00						
Occupational and Physical Therapy				\$50.00						
Preventive Care/Screening/Immunization		П								
Laboratory Outpatient and Professional Services	v	<u> </u>								
X-rays and Diagnostic Imaging	<u> </u>	<u> </u>								
Skilled Nursing Facility	✓	✓								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	V								_
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	All	All			All	All			□ All	
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	V			\$120.00					•	
Options for Additional Benefit Design Limits:			Plan Description	:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-FY						
Specialty Rx Coinsurance Maximum:	_		Plan HIOS ID:	41842DC004010	1-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):  Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of	П									
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Successf	ul.								
Actuarial Value:	71.09%									
Metal Tier:	Silver									
	NOTE: One or more					rvice with this co	st-sharing structure	e is covered at	100% by the plan in	the deductible
Additional Notes:	range. NOTE: Office	-visit-specific co	st-snaring is applyi	ing to x-rays in offic	ce settings.					
Calculation Time:	0.0703 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Tie	red Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiered	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?	_	71111001 001101	Dation 7 unio ant.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_						
		Plan Benefit De	1			2 Plan Benefit D				
Doduskihla (Ć)	<b>Medical</b> \$2,500.00	<b>Drug</b> \$250.00	Combined		Medical	Drug	Combined			
Deductible (\$) Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%								
MOOP (\$)	\$7,900									
MOOP if Separate (\$)	\$1,500	.00		-						
moor ii separate (y)							1			
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	6	
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	atter deductible
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	V	V								
All Inpatient Hospital Services (inc. MH/SUD)	>	✓								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$50.00						
					_					
Specialist Visit				\$100.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$100.00						
Services					l .					
Imaging (CT/PET Scans, MRIs)		<b>2</b>	54%	\$299.97						
Speech Therapy				\$50.00						
Occupational and Physical Therapy				\$50.00						
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	>	<b>v</b>								
X-rays and Diagnostic Imaging	>	✓								
Skilled Nursing Facility	Y	V								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	V								
Outpatient Surgery Physician/Surgical Services	V	<b>V</b>								
Drugs	☐ All	☐ All			☐ All	☐ All			□ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	>			\$75.00					V	
Specialty Drugs (i.e. high-cost)	>			\$120.00					•	
Options for Additional Benefit Design Limits:			Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-FY						
Specialty Rx Coinsurance Maximum:	_		Plan HIOS ID:	41842DC004010	1-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?  # Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of	П									
Copays?	<u> </u>									
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Successf	ul.								
Actuarial Value:	71.09%									
Metal Tier:	Silver									
	NOTE: One or more					vice with this co	st-sharing structure	e is covered at	100% by the plan in	the deductible
Additional Notes:	range. NOTE: Office	e-visit-specific co	st-sharing is applyi	ng to x-rays in offic	ce settings.					
Calculation Time:	0.0469 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options		Tie	ered Network O	ption			
Apply Inpatient Copay per Day?		HSA/HRA Emp	oyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	oution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		7 ii ii dai Contin	Jacion, anounc.		2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_						
		r 1 Plan Benefit De				2 Plan Benefit I	1 -			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,500.00	\$250.00								
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%								
MOOP (\$)		00.00								
MOOP if Separate (\$)										
Click Here for Important Instructions		Tie	r 1			-	ier 2		Tier 1	Tier 2
CHECK THE FOT IMPORTANCE HIST DECISIONS	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	•	separate	Copay applies only	after deductible
Medical	□ All	□ All	direction	зеринис	☐ All	All	different	Separate	☐ All	☐ All
Emergency Room Services	✓	✓								
All Inpatient Hospital Services (inc. MH/SUD)	V	V								Ō
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$50.00						
Specialist Visit				\$100.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient										
Services				\$100.00						
Imaging (CT/PET Scans, MRIs)	<b>V</b>	V								
Speech Therapy				\$50.00						
				450.00						
Occupational and Physical Therapy		Ш		\$50.00						
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	V	V								
X-rays and Diagnostic Imaging	V	✓								
Skilled Nursing Facility	V	V								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓			\$300.00					✓	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)				\$300.00	_	_				_
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ AII	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	~			\$120.00					V	
Options for Additional Benefit Design Limits:		1	Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-FY_POST_						
Specialty Rx Coinsurance Maximum:		-	Plan HIOS ID:	41842DC004010	1-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):		-								
Begin Primary Care Cost-Sharing After a Set Number of Visits? # Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of	П	-								
Copays?										
# Copays (1-10):										
Output		1								
Calculate										
Status/Error Messages:	Calculation Succes	ssful.								
Actuarial Value:	69.53%									
Metal Tier:	Silver									
		re services are not	subject to the ded	uctible and have no	copay. Any ser	rvice with this co	st-sharing structure	e is covered at	100% by the plan in	the deductible
Additional Notes:									vice(s) with fac/prof	
		ent inputs for those		•	-	•	-		•	•
Calculation Time:	0.043 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:	s	Tie	ered Network Op	tion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	Silver ▼									
Desired Metal Tier		I Plan Benefit De	scian		Tion	2 Plan Benefit D	ocian			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$2,500.00	\$250.00	Combined		ivieuicai	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%								
MOOP (\$)	\$7,900									
MOOP if Separate (\$)				-						
Click Here for Important Instructions		Tie					er 2		Tier 1	Tier 2
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only	after deductib
Medical	All	All			All	All			☐ All	All
Emergency Room Services	<b>V</b>	V								
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$50.00		П				П
				A-00.00						
Specialist Visit  Mental/Behavioral Health and Substance Use Disorder Outpatient		Ш		\$100.00						
Services				\$100.00						
Imaging (CT/PET Scans, MRIs)	V	V								
Speech Therapy				\$50.00						
Occupational and Physical Therapy				\$50.00	Ш	_				Ц
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	V	V								
X-rays and Diagnostic Imaging	<b>&gt;</b>	V								
Skilled Nursing Facility	V	✓								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	•								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs	>			\$40.00					<u> </u>	
Non-Preferred Brand Drugs	N [			\$75.00					V	
Specialty Drugs (i.e. high-cost)	•		Dian Danadatian	\$120.00					✓	
Options for Additional Benefit Design Limits:  Set a Maximum on Specialty Rx Coinsurance Payments?			Plan Description Name:	BH-FY_POST						
Specialty Rx Coinsurance Payments:  Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004010	1-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842	101					
# Days (1-10):	_									
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output Calculate										
Status/Error Messages:	Calculation Successi	Ful								
Actuarial Value:	71.07%									
Metal Tier:	Silver									
	NOTE: One or more	services are not	subject to the ded	uctible and have no	copay. Any ser	vice with this co	st-sharing structure	is covered at	100% by the plan in t	the deductible
Additional Notes:	range. NOTE: Office	e-visit-specific co	st-sharing is applyi	ing to x-rays in offic	ce settings.					
Calculation Time:	0.0508 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?	✓		HSA/HRA Options	s	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		7 ii ii dan Contan	out.on/wnount.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		4.01			_					
		r 1 Plan Benefit De	1	-		2 Plan Benefit D				
Deductible (\$)	Medical	Drug	\$2,600.00	-	Medical	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)			100.00%							
MOOP (\$)		l	\$6,700.00	+						
MOOP if Separate (\$)			\$0,700.00	→			<u> </u>			
			•			-	1			
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
Towns of Description	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Canau annliae anh	
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	arter deductible
Medical	<b>☑</b> All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	V			\$150.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	V			\$500.00					V	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<b>V</b>			\$25.00					✓	
Specialist Visit	V			\$50.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient	✓			\$50.00					~	
Services					_					
Imaging (CT/PET Scans, MRIs)	<u> </u>	<u>v</u>								
Speech Therapy	V			\$25.00					V	
Occupational and Bluminal Thomas	✓			\$25.00					✓	
Occupational and Physical Therapy Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services		<u> </u>								
X-rays and Diagnostic Imaging	V	V				H				
Skilled Nursing Facility	<b>V</b>			\$500.00					· ·	
		······································		2500.00						
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	✓								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	✓ AII	☐ All			☐ All	☐ All			✓ All	☐ All
Generics	V			\$10.00					V	
Preferred Brand Drugs	V			\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	V			\$120.00					V	
Options for Additional Benefit Design Limits:		1	Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-FZ						
Specialty Rx Coinsurance Maximum:	_		Plan HIOS ID:	41842DC004004	6-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):  Begin Primary Care Cost-Sharing After a Set Number of Visits?		-								
# Visits (1-10):	П									
Begin Primary Care Deductible/Coinsurance After a Set Number of	П									
Copays?										
# Copays (1-10):										
Output		ı								
Calculate										
Status/Error Messages:	Error: Result is out	side of [-4, +2] per	cent de minimis va	ariation.						
Actuarial Value:	72.77%									
Metal Tier:										
						vice with this co	st-sharing structure	is covered at	100% by the plan in	the deductible
Additional Notes:	range. NOTE: Offi	ce-visit-specific co	st-sharing is applyi	ing to x-rays in offic	ce settings.					
Calculation Time:	0.0547 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?	✓		HSA/HRA Options	s	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier					_					
		r 1 Plan Benefit De	, -			2 Plan Benefit D				
De dissabilita (A)	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)			\$2,600.00							
Coinsurance (%, Insurer's Cost Share) MOOP (\$)			100.00% \$6,700.00	-						
MOOP (\$)			\$6,700.00			T				
WOOF II Separate (3)							l			
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	y after deductible
Medical	✓ All	☐ All		<u> </u>	☐ All	☐ All			□ All	☐ All
Emergency Room Services	>			\$150.00					•	
All Inpatient Hospital Services (inc. MH/SUD)	<b>&gt;</b>	✓								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	V			\$25.00					✓	
Specialist Visit	V			\$50.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient	_	_		450.00		_			_	_
Services	$\mathbf{v}$			\$50.00					✓	
Imaging (CT/PET Scans, MRIs)	V	V								
Speech Therapy	V			\$25.00					V	
	V			\$25.00					V	
Occupational and Physical Therapy				\$25.00		_				_
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	V	✓								
X-rays and Diagnostic Imaging	>	✓								
Skilled Nursing Facility	· ·			\$500.00					V	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	•	•								
Outpatient Surgery Physician/Surgical Services	V	✓								
Drugs	<b>✓</b> All	☐ All			☐ All	☐ All			<b>✓</b> All	☐ All
Generics	Y		-	\$10.00					V	
Preferred Brand Drugs	>			\$40.00					V	
Non-Preferred Brand Drugs	>			\$75.00					V	
Specialty Drugs (i.e. high-cost)	>			\$120.00					V	
Options for Additional Benefit Design Limits:		-	Plan Description:	:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-FZ						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004004	6-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):		-								
Begin Primary Care Deductible/Coinsurance After a Set Number of	Ш									
Copays? # Copays (1-10):										
Output		J								
Calculate										
	Frror: Result is out	tside of [-4, +2] per	rent de minimis va	ariation						
	73.09%	or [ +, · 2] per	cent de minimilis ve	2.100.011.						
Metal Tier:	. 2.0370									
	NOTE: One or mor	re services are not	subject to the ded	uctible and have no	copay. Any sei	vice with this co	st-sharing structure	e is covered at	100% by the plan in	the deductible
Additional Notes:			-	ing to x-rays in office					,	
, additional rocco.	J		. 0	.,.	0-					
Calculation Time:	0.0586 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?	✓		HSA/HRA Options	s	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?	_				2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		I Plan Benefit De	scian		Tion	· 2 Plan Benefit D	Nocian			
	Medical	Drug	Combined	+	Medical	Drug	Combined			
Deductible (\$)	Wiedicai	Diug	\$2,600.00		Wicalcar	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)			100.00%							
MOOP (\$)			\$6,700.00							
MOOP if Separate (\$)				-						
									•	
Click Here for Important Instructions			er 1				er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
Medical	Deductible?  ✓ All	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	□ All	☐ All
Emergency Room Services	✓ All			\$150.00	□ All				☑ All	Aii
All Inpatient Hospital Services (inc. MH/SUD)	V			\$500.00					<b>V</b>	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	V			\$25.00					✓	
Specialist Visit	V			\$50.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient	1			ćro 00	_	_				_
Services	>			\$50.00					V	
Imaging (CT/PET Scans, MRIs)	V	V	61%	\$250.00						
Speech Therapy	V			\$25.00					V	
Occupational and Dispiral Theorem	V			\$25.00					V	
Occupational and Physical Therapy Preventive Care/Screening/Immunization						П				
Laboratory Outpatient and Professional Services		✓								
X-rays and Diagnostic Imaging	V	V				Ä				
Skilled Nursing Facility	·			\$500.00					<b>V</b>	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	✓	41%	\$250.00						
			41/0	\$230.00						
Outpatient Surgery Physician/Surgical Services	✓ ✓ All	☑ All			□ All	□ All			☐ ☑ All	
Drugs Generics	✓ All			\$10.00	□ All				✓ All	☐ All
Preferred Brand Drugs	N			\$40.00					V	
Non-Preferred Brand Drugs	] 🔽	Ö		\$75.00					V	
Specialty Drugs (i.e. high-cost)	] [>			\$120.00					V	
Options for Additional Benefit Design Limits:			Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-FZ_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004004	6-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?  # Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
	Calculation Success	ful.								
	69.23%									
	Silver									
			-				-		100% by the plan in	
Additional Notes:				ng to x-rays in offic	ce settings. NOT	L: Service-specif	ric cost-sharing is a	pplying for sei	vice(s) with fac/prof	components,
	overriding outpatier	it inputs for those	e service(s).							
Calculation Time:	0.0469 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?	•		HSA/HRA Option:	s	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:		1st	Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		Annual Contin	oution Amount.		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		4 Dl D 6'4 D-	-1	<b>-</b>	T'	2 Dia Dan 6't D				
		1 Plan Benefit De	1	-		2 Plan Benefit D				
Deductible (\$)	Medical	Drug	\$2,600.00	-	Medical	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)			100.00%							
MOOP (\$)			\$6,700.00	+		L				
MOOP if Separate (\$)			\$0,700.00	→		T T	1			
moor ii separate (y)							l			
Click Here for Important Instructions		Tie	er 1			Tie	er 2		Tier 1	Tier 2
- (- (-	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	C	
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible
Medical	<b>✓</b> All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	Y			\$150.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	>			\$500.00					✓	
Direction Constitute Tests and the constitution of the constitutio				¢25.00	_	_				_
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<b>&gt;</b>			\$25.00					✓	
Specialist Visit	V			\$50.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$50.00	П	_				_
Services	V			\$50.00	_				✓	
Imaging (CT/PET Scans, MRIs)	V	V	61%	\$250.00						
Speech Therapy	V			\$25.00					V	
Occupational and Physical Therapy	V			\$25.00					V	
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	>	V								
X-rays and Diagnostic Imaging	>	<b>V</b>								
Skilled Nursing Facility	Y			\$500.00					✓	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	✓								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	✓ All	☐ All			☐ All	□ All			✓ All	☐ All
Generics	~			\$10.00					V	
Preferred Brand Drugs	>			\$40.00					V	
Non-Preferred Brand Drugs	>			\$75.00					V	
Specialty Drugs (i.e. high-cost)	V			\$120.00					V	
Options for Additional Benefit Design Limits:			Plan Description	•						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-FZ_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004004	6-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):	_									
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output Calculate										
	Error: Bosult is aut	cido of [4 12] man	cont do minimis :	riation						
	Error: Result is out 72.06%	siue 01 [-4, +2] per	cent de minimis va	ıııatı011.						
Metal Tier:	/ 2.00/0									
	NOTE: One or mor	e services are not	subject to the ded	uctible and have no	conav Anvser	vice with this co	st-sharing structure	is covered at	100% by the plan in	the deductible
Additional Notes:	range. NOTE: Office		-			vice with this CO:	or onaring orracture	. is covered at	100/0 by the pidil iii	are deductible
Additional Notes.	.agc. NOTE. OTT	ce specific co	se sharing is applyi		e settings.					
Coloriation Times	0.0547									
Calculation Time:	0.0547 seconds									

User Inputs for Plan Parameters	_									
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:	s	Tie	red Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Empl	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?	_	/ unidar contin	oacion, ano anci		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		4 Dl D 6'4 D-	-1		T'	2 Dl D 6'4 D	!			
	Medical	1 Plan Benefit De	Combined	-	Medical	2 Plan Benefit D	Combined			
Deductible (\$)		Drug	\$2,600.00	-	iviedicai	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)			100.00%							
MOOP (\$)			\$6,700.00	┪						
MOOP if Separate (\$)			74,:00:00	-1			·			
			•							
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible
туре от венени	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies offi	arter deductible:
Medical	<b>✓</b> All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services	V			\$150.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	✓			\$25.00					V	
Specialist Visit	V			\$50.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient	✓			\$50.00					✓	
Services	_		61%	\$250.00						
Imaging (CT/PET Scans, MRIs) Speech Therapy	V		01%	\$25.00					☑	
эрееси тиетару				\$25.00						
Occupational and Physical Therapy	✓			\$25.00					✓	
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	☑	☑								
X-rays and Diagnostic Imaging	<u> </u>	✓								
Skilled Nursing Facility	<b>V</b>			\$500.00					✓	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	✓	41%	\$250.00						
			4170	7230.00		_ 				_
Outpatient Surgery Physician/Surgical Services	<b>V</b>	<b>V</b>								
Drugs	✓ AII	□ All		Ć40.00	All	☐ All			✓ All	☐ All
Generics Preferred Brand Drugs	<u> </u>			\$10.00 \$40.00					<u> </u>	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	·			\$120.00					<u> </u>	
Options for Additional Benefit Design Limits:			Plan Description	-						
Set a Maximum on Specialty Rx Coinsurance Payments?	. 🗆		Name:	BH-FZ POST						
Specialty Rx Coinsurance Maximum:	:		Plan HIOS ID:	41842DC004004	6-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):	:									
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output Calculate										
Status/Error Messages:	Calculation Success	ful								
Actuarial Value:	69.36%	rui.								
Metal Tier:	Silver									
		services are not	subject to the ded	uctible and have no	copay. Any ser	vice with this co	st-sharing structure	e is covered at	100% by the plan in	the deductible
Additional Notes:			-				-		vice(s) with fac/prof	
, additional recess	overriding outpatie			3	0			, 0	,	F/
Calculation Time:	0.0469 seconds		.,							
Carcaration Hiller	5.5705 SCC01103									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?	✓		HSA/HRA Options			ered Network Op				
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?  Desired Metal Tier										
Desired Metal Her		r 1 Plan Benefit De	sign	T	Tier	2 Plan Benefit D	esign			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)			\$2,600.00							
Coinsurance (%, Insurer's Cost Share)			100.00%							
MOOP (\$)			\$6,700.00							
MOOP if Separate (\$)										
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if		
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible
Medical	✓ All	☐ All		· ·	☐ All	☐ All		·	☐ All	☐ All
Emergency Room Services	>			\$150.00					V	
All Inpatient Hospital Services (inc. MH/SUD)	<b>&gt;</b>	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$25.00	_	_				_
Primary Care visit to Treat an injury or liness (exc. Preventive, and x-rays)	V			\$25.00					V	
Specialist Visit	V			\$50.00					V	
Mental/Behavioral Health and Substance Use Disorder Outpatient	<b>&gt;</b>			\$50.00					V	
Services					_					
Imaging (CT/PET Scans, MRIs)	D [	<u>v</u>	61%	\$250.00						
Speech Therapy	V			\$25.00					V	
Occupational and Physical Therapy	V			\$25.00					V	
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services	V	V								
X-rays and Diagnostic Imaging	V	~								
Skilled Nursing Facility	V			\$500.00					V	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	•	V								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	✓ All	☐ All			☐ All	☐ All			✓ All	☐ All
Generics	>			\$10.00					V	
Preferred Brand Drugs	>			\$40.00					V	
Non-Preferred Brand Drugs	V			\$75.00					V	
Specialty Drugs (i.e. high-cost)	V			\$120.00					✓	
Options for Additional Benefit Design Limits:		1	Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?	Ш		Name:	BH-FZ_POST_	C 04					
Specialty Rx Coinsurance Maximum:  Set a Maximum Number of Days for Charging an IP Copay?		+	Plan HIOS ID: Issuer HIOS ID:	41842DC004004 41842	6-01					
# Days (1-10):			issuel filos ib.	41042						
Begin Primary Care Cost-Sharing After a Set Number of Visits?	П									
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of		1								
Copays?										
# Copays (1-10):										
Output										
Calculate										
		tside of [-4, +2] per	cent de minimis va	ariation.						
	72.35%									
Metal Tier:	NOTE: One or mor	re ceruices are not	subject to the dod	uctible and have se	a consv. Any co	wice with this co	st-sharing structure	is covered at	100% by the plan in	the deductible
				ng to x-rays in offic		vice With this CO	st-stiding structure	e is covered at	100% by the plan in	ine deductible
Additional Notes:	range. NOTE. OIII	ec visit-specific co	ac anaring is applyi	ing to x-rays in Offic	ce settings.					
Calculation Time:	0.0469 seconds									
Calculation Title.	0.0402 3CC01105									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:	s	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Empl	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		7 ii ii dar Corieri	oacion, ano anci		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Platinum ▼	451 5 615		_	_					
		r 1 Plan Benefit De	1			2 Plan Benefit D				
Deductible (\$)	<b>Medical</b> \$250.00	<b>Drug</b> \$0.00	Combined		Medical	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)		00.00		<del> </del>		L				
MOOP if Separate (\$)		50.00		-						
			•			-				
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
- (- (-	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	C	- 60 1 1
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services				\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)	V	V								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$15.00						
Specialist Visit				\$30.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$30.00						
Services		✓								
Imaging (CT/PET Scans, MRIs) Speech Therapy				\$15.00						
Speech Therapy				313.00						
Occupational and Physical Therapy				\$15.00						
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services				\$30.00						
X-rays and Diagnostic Imaging				\$30.00						
Skilled Nursing Facility	V	V								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	<b>V</b>								
	✓	✓								
Outpatient Surgery Physician/Surgical Services	□ All	□ All			☐ All	□ All			□ All	☐ All
Drugs Generics				\$10.00					□ All	
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$100.00						
Options for Additional Benefit Design Limits:			Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-F2						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC0040059	9-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Succes	sful.								
Actuarial Value:	89.58%									
Metal Tier:	Platinum									
	NOTE: One or mor	e services are not	subject to the ded	uctible and have no	copay. Any ser	vice with this co	st-sharing structure	is covered at	100% by the plan in	the deductible
Additional Notes:	range.									
Calculation Time:	0.0508 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	s	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		, unidar conten	Dation / unio anti		2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Platinum 🔻				_					
		1 Plan Benefit De	1			2 Plan Benefit [				
Deductible (\$)	<b>Medical</b> \$250.00	<b>Drug</b> \$0.00	Combined		Medical	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$2,500									
MOOP if Separate (\$)		7.00		-						
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	6	-6
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	arter deductible
Medical	☐ All	☐ All			All	All			☐ All	☐ All
Emergency Room Services				\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)	<b>&gt;</b>	<b>V</b>								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$15.00						
Specialist Visit				\$30.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient										
Services				\$30.00						
Imaging (CT/PET Scans, MRIs)	V	V	58%	\$250.00						
Speech Therapy				\$15.00						
				\$15.00						
Occupational and Physical Therapy					_					
Preventive Care/Screening/Immunization				¢20.00						П
Laboratory Outpatient and Professional Services				\$30.00						
X-rays and Diagnostic Imaging Skilled Nursing Facility				\$30.00						
Skilled Nulshig Facility										
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	✓	37%	\$250.00						
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$100.00						
Options for Additional Benefit Design Limits:			Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-F2_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC0040059	9-01					
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):			Issuer HIOS ID:	41842						
Begin Primary Care Cost-Sharing After a Set Number of Visits?	_									
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?	_									
# Copays (1-10):										
Output										
Calculate Status/Error Messages:	Calculation Successi	Ful								
	88.02%	ui.								
	Platinum									
		services are not	subject to the ded	uctible and have no	copay. Any ser	vice with this co	st-sharing structure	e is covered at	100% by the plan in t	he deductible
Additional Notes:	range. NOTE: Service		-				-			
	-		5	• • • • • • • • • • • • • • • • • • • •		. 0			• •	
Calculation Time:	0.043 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option:	s	Tie	ered Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Empl	loyer Contribution	? 🗆	Tiere	d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contril	bution Amount:			t Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?		, umadi contin	oacion, ano anci		2nd	d Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Platinum 🔻	451 5 615		_	_	221 2 5:1				
		1 Plan Benefit De	1			2 Plan Benefit D				
Deductible (\$)	<b>Medical</b> \$250.00	<b>Drug</b> \$0.00	Combined		Medical	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)		00.00		<del>-</del>						
MOOP if Separate (\$)		0.00		-						
			•							
Click Here for Important Instructions		Tie	er 1			Ti	er 2		Tier 1	Tier 2
- (- (-	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	C	- 60 1 1
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	after deductible
Medical	☐ All	☐ All			All	☐ All			□ All	☐ All
Emergency Room Services				\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)	V	✓								
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$15.00						
Specialist Visit				\$30.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$30.00						
Services	L				_					
Imaging (CT/PET Scans, MRIs)	<u> </u>	<b>V</b>	58%	\$250.00						
Speech Therapy				\$15.00						
Occupational and Physical Therapy				\$15.00						
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services				\$30.00						
X-rays and Diagnostic Imaging				\$30.00						
Skilled Nursing Facility	✓	<b>V</b>								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	V	V								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			□ All	☐ All
Generics				\$10.00						
Preferred Brand Drugs				\$40.00						
Non-Preferred Brand Drugs				\$75.00						
Specialty Drugs (i.e. high-cost)				\$100.00						
Options for Additional Benefit Design Limits:		i	Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-F2_POST_						
Specialty Rx Coinsurance Maximum:	_		Plan HIOS ID:	41842DC0040059	9-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):  Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of	П									
Copays?										
# Copays (1-10):										
Output		l								
Calculate										
Status/Error Messages:	Calculation Succes	sful.								
Actuarial Value:	89.13%									
Metal Tier:	Platinum									
		e services are not	subject to the ded	uctible and have no	copay. Any ser	rvice with this co	st-sharing structure	e is covered at	100% by the plan in	:he deductible
Additional Notes:	range.									
Calculation Time:	0.043 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options		Tie	red Network Op	tion			
Apply Inpatient Copay per Day?		HSA/HRA Empl	oyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contrib	oution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_	_					
		r 1 Plan Benefit De		_		2 Plan Benefit D				
Deductible (\$)	\$0.00	<b>Drug</b> \$0.00	Combined		Medical	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)		00.00		-						
MOOP if Separate (\$)		1		-						
Wool in Separate (5)							l			
Click Here for Important Instructions		Tie	r 1			Ti	er 2		Tier 1	Tier 2
- (- (-	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	C	- ft d d
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	atter deductible?
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	All
Emergency Room Services				\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)										
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$15.00						П
Primary Care visit to Treat an injury or liness (exc. Preventive, and x-rays)				\$15.00	Ц					Ш
Specialist Visit				\$30.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$30.00						
Services	L			750.00						
Imaging (CT/PET Scans, MRIs)										
Speech Therapy				\$15.00						
				\$15.00						
Occupational and Physical Therapy	_	_			_	_				
Preventive Care/Screening/Immunization				ć20.00						
Laboratory Outpatient and Professional Services				\$30.00						
X-rays and Diagnostic Imaging		<u> </u>		\$30.00						
Skilled Nursing Facility										
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)										
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ AII	☐ All			☐ All	☐ All			□ All	☐ All
Generics				\$15.00						
Preferred Brand Drugs				\$25.00						
Non-Preferred Brand Drugs				\$50.00						
Specialty Drugs (i.e. high-cost)				\$100.00						
Options for Additional Benefit Design Limits:			Plan Description:	:						
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-F3						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001006	8-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of	Ш									
Copays? # Copays (1-10):										
Output # Copays (1-10).										
Calculate										
Status/Error Messages:	Calculation Succe	ssful.								
Actuarial Value:	90.20%									
Metal Tier:	Platinum									
		ecific cost-sharing is	applying for servi	ice(s) with fac/prof	components, ov	erriding outpation	ent inputs for those	service(s).		
Additional Notes:		0						.,		
Calculation Time:	0.0391 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options		Tie	red Network Op	tion			
Apply Inpatient Copay per Day?		HSA/HRA Empl	oyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contrib	oution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Platinum ▼	r 1 Plan Benefit De	alau.	<b>T</b>	Ties	2 Plan Benefit D	a a i a u			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$0.00	\$0.00	Combined		ivieuicai	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)		00.00		<b>T</b>		I.				
MOOP if Separate (\$)				_						
			•				<u>-</u>			
Click Here for Important Instructions		Tie	r 1			Ti	er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible?
	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	☐ All	☐ All			All	☐ All			☐ All	☐ All
Emergency Room Services				\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)										
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$15.00						
				400.00	_					_
Specialist Visit  Mental/Behavioral Health and Substance Use Disorder Outpatient	Ш	Ш		\$30.00					Ш	
Services				\$30.00						
Imaging (CT/PET Scans, MRIs)				\$150.00						
Speech Therapy				\$15.00						
Occupational and Physical Therapy				\$15.00						
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services				\$30.00						
X-rays and Diagnostic Imaging				\$30.00						
Skilled Nursing Facility		✓								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)				\$150.00						
				7	_					_
Outpatient Surgery Physician/Surgical Services	V	<b>V</b>								
Drugs	□ Ali	□ All		\$15.00	All	☐ All			□ AII	☐ All
Generics Preferred Brand Drugs				\$25.00						
Non-Preferred Brand Drugs				\$50.00						
Specialty Drugs (i.e. high-cost)				\$100.00						
Options for Additional Benefit Design Limits:			Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-F3_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC001006	8-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Calculate										
Status/Error Messages:	Error: Result is ou	tside of [-4, +2] per	cent de minimis va	ariation.						
Actuarial Value:	84.74%									
Metal Tier:										
	NOTE: Service-spe	ecific cost-sharing is	applying for servi	ce(s) with fac/prof	components, ov	erriding outpation	ent inputs for those	service(s).		
Additional Notes:										
Calculation Time:	0.0391 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Option			ered Network O				
Apply Inpatient Copay per Day?		HSA/HRA Emp	loyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contri	bution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	l Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?  Desired Metal Tier	□ Platinum ▼									
Desired Metal Her		r 1 Plan Benefit De	sian		Tior	2 Plan Benefit I	Design			
	Medical	Drug	Combined	1	Medical	Drug	Combined			
Deductible (\$)	\$0.00	\$0.00	Compiled		Medical	2.08	Compilied			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$5,0	00.00								
MOOP if Separate (\$)				<del></del>						
·					1					
Click Here for Important Instructions			er 1				ier 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies onl	, after deductible?
No. disal	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		
Medical	□ All	□ All		Ć250.00	☐ All	All			□ All	☐ All
Emergency Room Services All Inpatient Hospital Services (inc. MH/SUD)				\$250.00						
All impatient hospital services (inc. MH/SOD)	Ш								Ц	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$15.00						
Specialist Visit				\$30.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				·····						
Services				\$30.00						
Imaging (CT/PET Scans, MRIs)				\$150.00						
Speech Therapy				\$15.00						
				\$15.00						_
Occupational and Physical Therapy				\$15.00	_	_				_
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services				\$30.00						
X-rays and Diagnostic Imaging				\$30.00						
Skilled Nursing Facility		V								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		✓								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	□ All	☐ All			☐ All	All			□ All	☐ All
Generics				\$15.00						
Preferred Brand Drugs				\$25.00						
Non-Preferred Brand Drugs				\$50.00						
Specialty Drugs (i.e. high-cost)				\$100.00						
Options for Additional Benefit Design Limits:		-	Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments?			Name:	BH-F3_POST_						
Specialty Rx Coinsurance Maximum:	_	1	Plan HIOS ID:	41842DC001006	8-01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842						
# Days (1-10):  Begin Primary Care Cost-Sharing After a Set Number of Visits?										
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of	П	1								
Copays?										
# Copays (1-10):										
Output		_								
Calculate										
Status/Error Messages:	Calculation Succes	ssful.								
Actuarial Value:	89.64%									
Metal Tier:	Platinum									
	NOTE: Service-spe	ecific cost-sharing i	s applying for servi	ice(s) with fac/prof	components, ov	erriding outpati	ent inputs for those	service(s).		
Additional Notes:										
Calculation Time:	0.0391 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options		Tie	red Network Op	ition			
Apply Inpatient Copay per Day?		HSA/HRA Empl	oyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contrib	oution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier	Platinum 🔻			_	_					
		r 1 Plan Benefit De				2 Plan Benefit D				
Deductible (\$)	\$0.00	<b>Drug</b> \$0.00	Combined		Medical	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)		00.00		-						
MOOP if Separate (\$)		1		-						
							1			
Click Here for Important Instructions		Tie	r1			Ti	er 2		Tier 1	Tier 2
Town of Donnells	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Canau annliae anh	
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	arter deductible:
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	All
Emergency Room Services				\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)										
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$15.00						П
					_					
Specialist Visit				\$30.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$30.00						
Services										
Imaging (CT/PET Scans, MRIs)				Ć4F 00						
Speech Therapy				\$15.00						
Occupational and Physical Therapy				\$15.00						
Preventive Care/Screening/Immunization										
Laboratory Outpatient and Professional Services				\$30.00						
X-rays and Diagnostic Imaging				\$30.00						
Skilled Nursing Facility		✓		70000						
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)										
Outpatient Surgery Physician/Surgical Services	v	V								
Drugs	☐ AII	☐ AII			☐ All	☐ All			☐ All	☐ All
Generics				\$15.00						
Preferred Brand Drugs				\$25.00						
Non-Preferred Brand Drugs				\$50.00						
Specialty Drugs (i.e. high-cost)				\$100.00						
Options for Additional Benefit Design Limits:		1	Plan Description							
Set a Maximum on Specialty Rx Coinsurance Payments? Specialty Rx Coinsurance Maximum:			Name: Plan HIOS ID:	BH-F5 41842DC004006	0.01					
Set a Maximum Number of Days for Charging an IP Copay?			Issuer HIOS ID:	41842	0-01					
# Days (1-10):			issuel filos ib.	41042						
Begin Primary Care Cost-Sharing After a Set Number of Visits?	П									
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Succes	ssful.								
Actuarial Value:	90.20%									
Metal Tier:	Platinum	aifia aast shar!:!:		inale) with factors						
Additional Manage	NOTE: Service-spe	ecific cost-sharing is	applying for servi	ce(s) with tac/prof	components, ov	rerriaing outpatie	ent inputs for those	service(s).		
Additional Notes:										
0.1.1.1										
Calculation Time:	0.0391 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options		Tie	red Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Empl	oyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contrib	oution Amount:			: Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier		r 1 Plan Benefit De	cian		Tion	2 Plan Benefit D	Docian			
	Medical	Drug	Combined		Medical	Drug	Combined			
Deductible (\$)	\$0.00	\$0.00	Combined		Wicalcar	Diug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)	\$5,0	00.00								
MOOP if Separate (\$)				<del></del>						
Click Here for Important Instructions		Tie					er 2		Tier 1	Tier 2
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	Copay applies only	after deductible?
Bandtool	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate		☐ All
Medical Emergency Room Services	☐ All	□ All		\$250.00	All				□ All	
All Inpatient Hospital Services (inc. MH/SUD)				\$250.00						
***************************************										
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$15.00						
Specialist Visit				\$30.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$30.00	_	_				_
Services				\$30.00						
Imaging (CT/PET Scans, MRIs)				\$150.00						
Speech Therapy				\$15.00						
0 1 171				\$15.00						
Occupational and Physical Therapy					_	_				
Preventive Care/Screening/Immunization  Laboratory Outpatient and Professional Services				\$30.00						
X-rays and Diagnostic Imaging				\$30.00		H				
Skilled Nursing Facility		<u> </u>		\$30.00						
				<b>*</b>						
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)				\$150.00						
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$15.00						
Preferred Brand Drugs				\$25.00						
Non-Preferred Brand Drugs				\$50.00						
Specialty Drugs (i.e. high-cost)  Options for Additional Benefit Design Limits:			Plan Description:	\$100.00	Ш					
Set a Maximum on Specialty Rx Coinsurance Payments?	П	1	Name:	BH-F5_POST_						
Specialty Rx Coinsurance Maximum:			Plan HIOS ID:	41842DC004006	0-01					
Set a Maximum Number of Days for Charging an IP Copay?		1	Issuer HIOS ID:	41842						
# Days (1-10):										
Begin Primary Care Cost-Sharing After a Set Number of Visits?		1								
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):		J								
Output Calculate										
Status/Error Messages:	Error: Result is our	tside of [-4, +2] per	cent de minimis va	riation.						
Actuarial Value:	84.74%	or [ ¬, · ∠] per	CC GC 1111111111111111111111111111111							
Metal Tier:										
	NOTE: Service-spe	ecific cost-sharing is	applying for servi	ce(s) with fac/prof	components, ov	erriding outpation	ent inputs for those	service(s).		
Additional Notes:										
Calculation Time:	0.0312 seconds									

User Inputs for Plan Parameters										
Use Integrated Medical and Drug Deductible?			HSA/HRA Options		Tie	red Network Op	otion			
Apply Inpatient Copay per Day?		HSA/HRA Empl	oyer Contribution	? 🗆		d Network Plan?				
Apply Skilled Nursing Facility Copay per Day?		Annual Contrib	oution Amount:			Tier Utilization:				
Use Separate MOOP for Medical and Drug Spending?					2nd	Tier Utilization:				
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?										
Desired Metal Tier				_	_					
		r 1 Plan Benefit De		_		2 Plan Benefit D				
Deductible (\$)	\$0.00	<b>Drug</b> \$0.00	Combined		Medical	Drug	Combined			
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%								
MOOP (\$)		00.00		-						
MOOP if Separate (\$)		1		-						
moor ii separate (y)							1			
Click Here for Important Instructions		Tie	r1			Ti	er 2		Tier 1	Tier 2
- (- (-	Subject to	Subject to	Coinsurance, if	Copay, if	Subject to	Subject to	Coinsurance, if	Copay, if	C	- 60
Type of Benefit	Deductible?	Coinsurance?	different	separate	Deductible?	Coinsurance?	different	separate	Copay applies only	atter deductible?
Medical	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Emergency Room Services				\$250.00						
All Inpatient Hospital Services (inc. MH/SUD)										
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$15.00						П
Fillinary care visit to freat arrinjury or filliess (exc. Freventive, and x-rays)				\$15.00						_
Specialist Visit				\$30.00						
Mental/Behavioral Health and Substance Use Disorder Outpatient				\$30.00						
Services	L									
Imaging (CT/PET Scans, MRIs)				\$150.00						
Speech Therapy				\$15.00						
Occupational and Bluster Thomas				\$15.00						
Occupational and Physical Therapy Preventive Care/Screening/Immunization		П								
Laboratory Outpatient and Professional Services				\$30.00						
X-rays and Diagnostic Imaging				\$30.00		H				
Skilled Nursing Facility		<u> </u>		\$50.00						
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		V								
Outpatient Surgery Physician/Surgical Services	V	V								
Drugs	☐ All	☐ All			☐ All	☐ All			☐ All	☐ All
Generics				\$15.00						
Preferred Brand Drugs				\$25.00						
Non-Preferred Brand Drugs				\$50.00						
Specialty Drugs (i.e. high-cost)				\$100.00						
Options for Additional Benefit Design Limits:	_	٦	Plan Description:							
Set a Maximum on Specialty Rx Coinsurance Payments?	Ш		Name:	BH-F5_POST_	0.04					
Specialty Rx Coinsurance Maximum:		_	Plan HIOS ID: Issuer HIOS ID:	41842DC004006	0-01					
Set a Maximum Number of Days for Charging an IP Copay? # Days (1-10):			issuer HIOS ID:	41842						
Begin Primary Care Cost-Sharing After a Set Number of Visits?	П									
# Visits (1-10):										
Begin Primary Care Deductible/Coinsurance After a Set Number of										
Copays?										
# Copays (1-10):										
Output										
Calculate										
Status/Error Messages:	Calculation Succe	ssful.								
Actuarial Value:	89.64%									
Metal Tier:	Platinum			(-)ial- 5		a matatha m				
A Life Land	NUTE: Service-spe	ecific cost-sharing is	applying for servi	ce(s) with fac/prof	components, ov	erriding outpation	ent inputs for those	service(s).		
Additional Notes:										
Calculation Time:	0.0391 seconds									

**Exhibit - Plan Mapping**State: DC | | Market Segment:Small Group | | Company: UnitedHealthcare Insurance Company | | HIOS Issuer ID: 41842 | | Proposed Effective Date: 1/1/2019

	BETWEEN EXPERIENCE &	EFFECTIVE DATE	
EXPERIENCE PERIOD	RATING PERIOD:	of FILING:	PROPOSED PORTFOLIO & AUTO -
PLAN LIST	Plan Additions &	Plan Additions &	ENROLLMENT
	Terminations	Terminations	MAPPING
41842DC0010001		TERMINATED	
41842DC0010006			41842DC0010006
41842DC0010031		TERMINATED	
41842DC0010032			41842DC0010032
41842DC0010042			41842DC0010042
41842DC0010043			41842DC0010043
41842DC0010054			41842DC0010054
41842DC0010066			41842DC0010066
41842DC0010068			41842DC0010068
41842DC0010069		TERMINATED	
41842DC0010074			41842DC0010074
41842DC0040045			41842DC0040045
41842DC0040046			41842DC0040046
41842DC0040047		TERMINATED	
41842DC0040052		TERMINATED	
41842DC0040053		TERMINATED	
41842DC0040091			41842DC0040091
41842DC0040101			41842DC0040101
41842DC0010075		TERMINATED	
41842DC0010076		TERMINATED	
41842DC0010077		TERMINATED	
41842DC0010078			41842DC0010078
41842DC0010079		TERMINATED	
41842DC0010080			41842DC0010080
41842DC0040008			41842DC0040008
41842DC0040054		TERMINATED	
41842DC0040055		TERMINATED	
41842DC0040056		TERMINATED	
41842DC0040057			41842DC0040057
41842DC0040058		TERMINATED	
41842DC0040059			41842DC0040059
41842DC0040060			41842DC0040060
		41842DC0010081	41842DC0010081
		41842DC0010082	41842DC0010082
		41842DC0010083	41842DC0010083
		41842DC0010084	41842DC0010084
		41842DC0040061	41842DC0040061
		41842DC0040062	41842DC0040062
		41842DC0040063	41842DC0040063
		41842DC0040064	41842DC0040064



Efren Tanhehco Supervisory Actuary Department of Insurance, Securities and Banking 810 First Street, NE, Ste. 701 Washington, DC 20002

## RE: Proprietary and Confidential Information UnitedHealthcare Risk Adjustment Data

HIOS Issuer IDs: 21066 UnitedHealthcare of the Mid-Atlantic, Inc.; 41842 UnitedHealthcare Insurance Company; 75753 Optimum Choice, Inc.

Dear Mr. Tanhehco:

The companies listed above (collectively referred to herein as "United" in either the singular or plural forms) are submitting data for the 2017 RATEE files at the request of the Department of Insurance, Securities and Banking. United submits in confidence this carrier-specific private data and this letter applies to any submission reasonably correlating to the 2017 RATEE files.

Under state law, this carrier-specific private information is non-financial, strictly confidential proprietary commercial information and not subject to disclosure under the D.C. Code § 2-534(a), CDCR 1-406.2, and is not a public record subject to disclosure requirements under D.C. Code § 2-534. It is non-public information submitted in confidence to the insurance commissioner that would give advantage to a competitor. Disclosure of this information would be detrimental to the best interests of the public because plan issuers compete on a product strategy that entices consumers to purchase its products and increase plan membership. Knowing a competitor's strategy beforehand confers a competitive advantage to issuers with sufficient resources to adjust to the competitor's strategy before going to market instead of waiting until the next adjustment window in a market. If a filing's confidential information such as risk scores prompts an issuer to see it is the only one offering a certain type of product (e.g. a wide network metal level (platinum) or cost sharing feature (0% member cost sharing for emergency room visits)), then issuers with sufficient resources to adjust have an unfair advance opportunity to remove those plans or adjust strategies. For example, if an issuer sees the competition has an emergency room copay of \$500 but they had \$250, it can likewise adjust to \$500 before going to market, which deprives consumers of the opportunity to take advantage of issuer competitive behavior.

We respectfully request the Department refrain from disclosing United's carrier-specific information to any other entity. Disclosure may cause substantial competitive harm by giving an unfair advantage to our competitors that is specific and reasonably foreseeable. Re-disclosure would enable competitors to model the above-named company's business portfolios pertaining to these submissions and unfairly adjust their strategy before going to market instead of waiting until the next opportunity to adjust in the relevant market. Accordingly, we respectfully request carrier-specific information not be redisclosed to any other person, including state or federal regulatory agencies, unless United consents in writing to the disclosure and the recipient agrees in writing prior to receipt to maintain the confidential proprietary and/or trade secret nature of the information.

Thank you in advance for your cooperation with this request.

Sincerely,

Associate General Counsel